MINIMUM MORAL RIGHTS: ALABAMA MENTAL HEALTH INSTITUTIONS

AND THE ROAD TO FEDERAL INTERVENTION

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MINIMUM MORAL RIGHTS: ALABAMA MENTAL HEALTH INSTITUTIONS AND THE ROAD TO FEDERAL INTERVENTION

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A Thesis

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Masters of Arts

Auburn, Alabama
December 19, 2008

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Deborah Jane Belcher was born in Mt. Clemons, Michigan. A graduate of Marshall Lab School in Huntington, West Virginia, Deborah attended Marshall University where she graduated with a Bachelor of Science in Art and Speech Education. After retiring from Delta Airlines, she enrolled at Auburn University to pursue a Masters of Arts in Modern American History.

THESIS ABSTRACT

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Master of Arts, December 19, 2007
(B.S., Marshall University)

196 Typed Pages

Directed by David Carter

This thesis explores the history of the abuse to the patients in Alabama's Mental Health Hospitals from 1860 to 1970. It addresses the social norms that encouraged the abuse, the legal aspects that endorsed the abuse, the political forces that compound the abuse, and the medical and administrative policies of the superintendents and their staff that executed the abuse. It concludes by relating the events that led to the landmark federal ruling in the *Wyatt v. Stickney* case that ended the abuse and guaranteed the patients their minimum moral rights. The significance of the case lies in the fact that it ensured all mentally disabled citizens throughout the nation the right to adequate medical treatment.

ACKNOWLEDGMENTS

I would like to thank my committee, Drs. David Carter, Larry Gerber, and Charles Israel. I would also like to thank Mrs. Joyce Hicks and Dr. Dwayne Cox of the Special Collections and Archives Department of Auburn University and Dr. Norwood Kerr of the Alabama Department of Archives and History for their assistance in researching this project. A special thanks goes to Dr. Wayne Flynt for introducing me to the topic and for his assistance and support throughout the writing of the thesis. Of course, without the constant love, encouragement, and tenacity of my sister, Donna Robyn, I could have never completed the project. Finally, I would like to dedicate the thesis to the memory of my parents, Lucy Alice Jane (Hiser) and Henry Edison Belcher.

Style manual used: Kate L. Turabian, *A Manual for Writers of Term Papers, Theses, and Dissertations*. 6th edition. Chicago: University of Chicago Press, 1996.

Computer software used: Microsoft Word, 2003.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I. INTRODUCTION

Less than a decade before the outbreak of the Civil War, the Alabama Legislature acknowledged the state's social, legal, and political responsibility for the protection and the cure of the insane by procuring laws and appropriating funds for the establishment of a mental health institution. Secretary of State William Garrett's *Reminiscences of Public Men in Alabama, for Thirty Years* stated that the House of Representatives intended the Act of 1852 to provide for "the protection is the end of our afflicted people as the duty of the State, as high, as obligatory, as that of securing to her citizens the enjoyment of liberty and state."[1] Ensuring legal protection for all citizens, the Act required a county probate judge, before committing a patient to an asylum, to have on record a creditable physician's statement accompanied with a similar statement of a disinterested person, both verifying the person's insanity. Finalizing their obligation, the legislators also appropriated a building fund of one hundred thousand dollars and a three hundred acre tract of land outside of Tuscaloosa for the construction of a first-class hospital that would provide moral treatment to indigent Alabamians who suffered from mental disabilities. The Alabama Legislature proudly opened its first state funded mental health asylum, the

[1]William Garrett, *Reminiscences of Public Men in Alabama, for Thirty Years* (Atlanta: Plantation Publishing Company's Press, 1872), 520.

Alabama Insane Hospital on July 6, 1861, six weeks following the state's seccession from the union.[2]

By the end of the war, Alabama's government was experiencing both financial and political crises. The state's currency was worthless, and the majority of the farmland remained uncultivated, resulting in the diminution of the goals and the dilution of the financial funding intended for the care of the mentally ill. Alabama's prior political structure was also in a precarious condition; gone were the ways of slavery, yeomen farmers, and an oligarchic government of wealthy landowners. As the period of self-reconstruction gave way to Congressional Reconstruction, the Republican Party ultimately came to control the state government, a party that welcomed the participation of poor white farmers and African-Americans; a period of reconstruction.

But that disruption of the state's traditional power proved short-lived. By 1875, the Reconstruction Era had ended, and along with it, the liberal power of the Republican Party. The Democrats, dominated by a small clique of planters from Alabama's black-belt region, had regained control of the Legislature. They indisputably blamed the demise of state rights and the impoverished economic conditions of the previous ten years on the political synergy of small farmers, tenant farmers, and sharecroppers of both races. Vowing to return the ways of the past to the present, the Democratic Redeemers wrote a new state constitution, one that cut taxes and terminated liberal social welfare programs that assisted the poor and the mentally ill. In addition, the Alabama legislature passed the "Separate but Equal Accommodation Bill" in 1891, which created additional social ostracism for African-Americans, an action later given sanction in the 1896 U.S.

[2]Alabama, *Acts of Alabama, 1851-1852* (Montgomery: Brittan and DeWolf, State Printers, 1852), 11-15.

Supreme Court ruling of *Plessy v. Ferguson*. Aware of its social and legal implications, the legislators falsely argued that the separate but equal bill protected and shielded blacks from insulting encounters with whites; whereas, realistically, its goal was to separate and isolate blacks from whites, even those in asylums.

In his article, "Social Change and Sectional Identity," historian Numan Bartley refers to I. A. Newby's definition of a Southerner as anyone white or black "who finds himself more or less preoccupied with that association, his life more or less defined by it."[3] Bartley argues that throughout the centuries, the South has had its own image, its own culture, based on racial differences and class structure. Strengthening his argument of a cultural base society, Bartley refers to David M. Potter's "The Enigma of the South" thesis that the economic burden of a cash crop, along with its rural lifestyle, produced an environment among its poor that evolved into "the folk culture of the South."[4] This folk culture produced distinctive southern social mores of work ethics and honor that were based on a relationship among men that conveyed a distinctive attitude and behavior encapsulated with a strong sense of pride and dignity.[5] Many of these "folks" were white and African-American small farmers, tenant farmers, and sharecroppers who could not read or write; consequently, their daily life pivoted around manual labor, using their word or handshake as verification of their labor contracts. However, after generations of poor yields of cotton crops, whites and blacks alike were unable to fulfill their financial contracts, lost their land and homes to those holding their mortgages. As a byproduct of

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[3]Numan V. Bartley, "Social Change and Sectional Identity," *The Journal of Southern History*, vol. LXI, no. 1 (February 1995), 9.

[4]Bartley, 7.

[5]Bartley, 4-11.

poor economic conditions, they experienced social rejection as a inferior class and /or race, unworthy of assistance. Out of desperation, the kin of these hungry and homeless folks sought a place for their survival, and many found this refuge in asylums.

This economic depression helped to deliver the formation of a social and political party that brought both white and black tenant farmers and sharecroppers under the same banner, the Populist Party. According to historian Wayne Flynt's *Poor But Proud: Alabama's Poor Whites*, the Populist movement reflected the loss of family owned farms, a devastating phenomenon because owning one's land "determined a farmer's self-worth."[6] By 1896, Alabama's Populist Party had broadened its coalition to include low wage earners such as industrial workers, coal miners, and railroad workers, both white and black. Faced with this challenge, the Alabama Democratic Party, fearful of the power of the poor, proclaimed that the African-Americans' involvement in the Populist Party had heightened the threat of the black vote. Equally disturbing for Alabama's white citizens was the additional allegation from Democratic Party leaders that the white tenant farmers and sharecroppers' involvement in the Populist Party had split and would continue to split the white vote, thereby adding to the unacceptable possibility of liberal policies and the decline of the ingrained value of white supremacy and the caste system.[7]

Growing up poor and physically disabled in Arkansas, leading sociologist Rupert

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[6]Wayne Flynt, *Poor But Proud: Alabama's Poor Whites* (Tuscaloosa, Ala.: The University of Alabama Press, 1989), 253, 244–253. Even until the mid-1900s, landownership "determined a farmer's self-worth. It also "created a typical class division compounded by the size of his farm and the color of his skin." *See also* Wayne Flynt, *Alabama in the Twentieth Century* (Tuscaloosa, Ala.: The University of Alabama Press, 2004), 185.

[7]Flynt, *Poor But Proud*, 6, 254–257. Populists terrified conservative Democrats, especially in the Black Belt, where planters envisioned a neo-Reconstruction coalition taking over and imposing higher taxes. See also Sheldon Hackney, *Populism to Progressivism in Alabama* (Princeton: Princeton University Press, 1969), 33–47.

B. Vance was well aware of the South's cultural biases and class structure.[8] Vance's *Human Factors in Cotton Culture* argues society, looking for a deflection to blame for their exploitation of the small farmers, found it convenient to categorize the poor cotton farmers as genetically lazy, simple-minded folks. He also stated that in order to compensate for their lack of moral obligations to the poor and uneducated, leading white southerners agreed with the psychologist's view that intelligence was hereditary. Unwilling to accept these allegations, Vance instead argued that the farmers were the offshoot of the region's stubborn devotion to a volatile cash crop that required low-wage laborers. He referred to these southern biases as a "cotton culture complex." Subsequently, as the social underdogs, the burden of providing cheap labor and its ensuing health problems fell on the shoulders of the region's tenant farmers and sharecroppers.[9]

Feeling a personal bond to these indigents, Vance asserted that the farmers' problems were sociological, encompassing both biological and cultural factors. The biological factors stemmed from the farmers' meager yearly crops, resulting in little, if any wages. Without wages, the farmer and his family could barely provide or survive in an environment of inadequate housing and food. Thus, their lethargic behavior resulted from poor diets consisting of meat (fatback), meal, and molasses, which created a biological deficiency and commonly resulted in pellagra. The illness, if left unattended,

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[8]John Shelton Reed and Daniel Joseph Singal, eds. *Regionalism and the South: Selected Papers of Rupert Vance* (Chapel Hill: The University of North Carolina Press, 1982), x. Vance had contracted polio at the age of three, resulting in the lost of usage of both legs and being stigmatized as a cripple throughout his life. In addition, when Vance was a small boy, his father, a merchant and cotton planter, had to file bankruptcy because of debts, resulting in the family struggling financially for years.

[9]Rupert B. Vance, *Human Factors in Cotton Culture: a Study in the Social Geography of the American South* (Chapel Hill: The University of North Carolina Press, 1929), 311–13.

could result in severe nervous disorders, insanity, and eventually death. Compounding the problem was the fact that at the beginning of the twentieth century, doctors considered these disorders contagious. Thus, public fears triggered an influx of pellagra and other contagious patients to be civilly committed to state supported mental institutions. Even more disconcerting was the fact that when public health officials attempted to tackle these diseases, farmers became defensive. According to Vance, this was logical because society had always viewed the patients' ailments "as an indication of ignorance, filth, and poverty."[10]

Vance claimed the rich planters with their cotton culture complex developed the concept of inherent inferiority and promoted the cultural degradation of manual labor in order to maintain cheap labor. Strengthening the concept of inferiority was the fact that most laborers were isolated from towns and schools. Hence, the farmers also remained uneducated and backward which helped to cement the notion that they were not worthy of assistance, respect, or dignity. Eventually, society came to judge the white and black sharecroppers who made-up sixty percent of Alabama's farmers as the equivalents of slaves and slave labor. Vance adamantly argues that there was a marked division between "classes in the agricultural South … the banker-merchant-landlord class and the tenant-small landowner class, and the former class have made its money from the latter class."[11]

Unfortunately for the indigents, the banker-merchant-landlord class was the controlling class of the Alabama Legislature. Furthermore, the political Bosses, feeling betrayed by the tenant farmers and sharecroppers who had promoted Populist ideologies

[10]Vance, 297–298.

[11]Vance, 214–217, 311.

around the turn of the century, and in doing so had questioned their immoral practices of white supremacy and slave labor, were determined to cement their political hegemony for the indefinite future. Determined that they would never again face a political challenge like the Populist revolt, Alabama's ruling white Democrats removed a considerable proportion of poor whites from the electorate by enacting a new state constitution requiring literacy tests and poll taxes. According to Governor Joseph F. Johnston, a class of people regarded as "a constant menace to its [the state] growth and to the security of life and property."[12] Consequently, the legal restrictions denying Alabama's poor the right to vote allowed the legislative Bosses to create a political machine that responded primarily to special interest groups representing the affluent and the growing white middle-class. The 1901 Constitution safeguarded these changes by solidifying white supremacy and reinforcing one-party politics committed to low taxes and low appropriations. An action ensuring that the state's social welfare programs and mental health institutions that assisted the poor farmers and sharecroppers would remain inadequate for years to come.[13]

Whereas the core of the Populist revolt had been in the state's rural regions and among the farmers who resided there, but at the onset of the industrial revolution, the state's political demographics changed. Urban centers, the white middle-class, and certain industrial wage earners took center stage in the new national political movement and the new era, the Progressive Party and the Progressive Era. Although Alabama's

[12]Alabama, *Journal of the House of Representatives of the State of Alabama, Session of 1896-7* (Montgomery, Ala.: Roemer Printing Company, State Printers and Binders, 1897), 386.

[13]Flynt, *Poor But Proud*, 257. The new constitution allowed local registrars to use literacy tests and good character clauses to eliminate both white and black voters. All voters had to pay the annual $1.50 poll tax, an accumulative bill.

demographics mirrored national trends in some respects, it was diverged in many important ways. Granted, farmers of both races left their homes for factory jobs in Birmingham or for millwork in various mill villages, but Alabama's primarily work-force still remained farmers who continued to grow a singular cash crop, King Cotton.

Urban organizations, women's social clubs, schools, and citizens such as ministers and social workers became involved in proliferating public awareness of the medical benefits of proper hygiene for those who had left the farms and their kin. With this effort for improvement, came the hope to eradicate diseases many thought to be contagious, such as malaria, tuberculosis, hookworm, and pellagra.[14] Consequently, the Progressive Era did usher in some beneficial social changes in urban areas, but beyond the awareness of public health safeguards shared among kin, few social service programs reached rural Alabama.

Additionally, Alabama's awareness of progressive health benefits was in itself, somewhat limited. Hugh Bailey's *Liberalism in the New South: Southern Social Reform and the Progressive Movement* maintains that the South developed an indigenous progressive movement focused on regional social issues, such as health problems that were the byproducts of its economic livelihood of cotton, timber, and steel. For example, with the increase of product demand, the concern for regular attendance of employees became a major issue for the owners of mills, lumberyards, and factories. Accompanied with the need for attendance was also the awareness of the class and social make-up of

[14]Flynt, *Poor But Proud*, 175, 207–208, 257–262, 276. In June 1914, Dr. Joseph Goldberger, a Jewish immigrant working for the U.S. Public Health Service, correctly diagnosed the cause of pellagra, a diet consisting predominantly of meat (fatback), meal, and molasses, the typical meal of a tenant farmer. Pellagra became known as a possible fatal condition often referred to as "the disease of the four d's: diarrhea, dermatitis, dementia, and death."

the employees, consisting primarily of former tenant farmers and sharecroppers. Thus, the employers sought a solution to "their" types of illnesses, especially the contagious diseases the laborers contracted and carried among themselves.[15]

George B. Tindall offers considerable insight into this dilemma in *The Emergence of the New South, 1913–1946.* Tindall traces a pattern in southern states where as the need for a more communal work force increased, the development of public health services grew in tandem. With this growth, over time, came the cures for the "lazy" diseases, such as hookworm, tuberculosis, and pellagra. In addition, as the Era of rationality and efficiency advanced, progressive medical policymaking developed into public welfare agencies. The agencies moved the medical treatment of infectious diseases into the phase of institutionalization and state supported hospitals.[16] In other words, a major element of the Progressive Era and progressive medicine entailed the legal eradication of afflicted citizens from contact with the public and embodied a civilization intolerant of the weak-minded.

Regrettably, as the nation entered the Great Depression Era, the indigents faced additional social setbacks. The National Public Health Service now indicated syphilis, a sexually transmitted disease, as the most serious public health problem for poor southerners, both white and black.[17] In advanced stages, the contagious disease caused insanity and death. As with pellagra before it, syphilis also caused a substantial increase

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[15]Hugh C. Bailey, *Liberalism in the New South: Southern Social Reform and the Progressive Movement* (Coral, Fla.: University of Miami Press, 1969), 4–6.

[16]George B. Tindall, *The Emergence of the New South, 1913–1946* (Baton Rouge: Louisiana State University Press, 1967), 276–282.

[17]Tindall, 279–282.

of indigents involuntarily committed to state asylums. Added to this influx of contagious patients to the state supported institutions were epileptics and the feebleminded. The harsh vocabulary of the "feebleminded," "idiots," "imbeciles," and "morons" was grounded in the belief that such conditions were another example of heredity afflictions found most commonly among the poor. Through moral scrutiny, social and political forces judged it necessary to isolate these citizens in asylums as well.

Throughout the thesis, language describing mental illnesses and mental disabilities is duplicated from its original usage. Steven Noll's *Feeble-Minded in our Midst* provides one with a board insight into how perceptions and classifications have changed over the decades. For example, Noll's lists the 1920s classification of someone as "moron" would today be classified as mild, educable mentally handicapped with an IQ of 70-55, "imbecile" as moderate, trainable mentally handicapped with an IQ of 25-55, and "idiot" as severe, profound mentally handicapped with an IQ of <25.[18] Such language and diagnostic vocabulary offer a useful window into the attitudes about mental health in a different era, but is obviously dated and carries within it a number of embedded cultural, racial, class-based, and gendered assumptions.

Placing a stamp of approval on this practice of involuntary commitment was the U. S. Supreme Court's *Buck v. Bell* decision that legally allowed the sterilization of institutionalized women adjudged to suffer from defective mental capacity. However, except for a quick fix of institutionalization, the growing awareness of social and human rights of the afflicted remained uninvestigated and removed from critical analysis for social reform. By allowing constituents to commit the afflicted and the defective in order

[18]Steven Noll, *Feeble-Minded in our Midst: Institutions for the Mentally Retarded in the South, 1900-1940* (Chapel Hill: University of North Carolina Press, 1995) 3.

to remove their presence from the community and to avert the spread of contagious diseases, Alabama's leading citizens skirted their responsibilities in addressing the denial of the patients' civil rights. As generations of indigents inhabited the asylum, a patter of institutional neglect came to characterize the Legislature, with it perennially ignoring the needs of white and African-American indigents and allocating only modest sums for their survival.

In the decades following the opening of the doors of the Alabama Insane Hospital in 1861, the Legislature, dominated by laissez-faire ideas, steadily relinquished its political responsibilities in overseeing and safeguarding the moral treatment of the indigent patients. Repeatedly, the state certified the Board of Trustees and superintendents' administrative policies that conveyed the South's ingrain practice of social Darwinism. Equally problematic for the indigents was the fact that the Legislature appropriated insufficient funds for minimal maintenance of the institution, as it simultaneously required segregated accommodations for the patients and staff within the facilities. Consequently, segregation placed an enormous financial drain on the hospital's budget with its requirement of "separate" facilities by race. Jim Crow's growing shadow also helped to rationalize the incorporation of occupational therapy into the administration's method of moral treatment. As the asylum's census grew, occupational therapy evolved into plantation labor that involved all but the literate, white male inmates who were unaccustomed to manual labor and the white female patients, who, due to social convention, could not work as farm laborers. This created the cogitation of discrimination by class and race in the application of moral treatment among the patients. Far from challenging these conditions, the state's political leadership actively endorsed

the Board of Trustees and superintendents' approach to running the institutions, unable to perceive the gross inefficiencies in the approach, and seemingly unconcerned about maximizing the patients' rights to curative treatment.

At times, human characteristics of greed and vanity, combined with a quest for professional and social recognition also influenced the Board of Trustees and the superintendents' policies of moral treatment and occupational therapy. These characteristics contributed in the transformation of the hospital from one intended to help the mentally ill indigent to one abusing the patients in a plantation system of slave labor without medical treatment. To the public on the outside, the hospital represented an institution of hope and progressive methods for curing the mentally ill. On the inside, it represented a lost hole and a convenient depository for the unwanted.

Due to the institution's financial needs and legal authority, the patients had few possibilities of leaving the asylum. However, after World War II, the traditional social and political attitudes of the previous decades on the moral treatment of the patients evolved into a growing interest in mental health. Hence, as the social protest for human rights grew in the 1950s and 1960s, the call for improved treatment and facilities for the disabled gained some momentum. Nevertheless, the institution continued to operate as a custodial warehouse.

In 1970, a landmark class suit filed in the United States Middle District Court of Alabama against the Alabama Mental Health Board addressed the mentally ill patients' rights to receive constitutional and moral treatment when civilly committed to a state mental health hospital. During litigation of the *Wyatt v. Stickney* case in the months that followed, the court concluded that neither state nor federal guidelines existed or had ever

existed for the rights of the mentally ill or retarded. The federal court ruled that a set of minimum moral standards were imperative in order to guarantee involuntary committed patients their constitutional rights of liberty and due process.[19] Subsequently, the court constructed a set of minimum constitutional standards for citizens in Alabama's mental health institutions. The minimum standards became the first written guidelines for legal and medical professionals to follow when addressing the prevention of abuse and the constitutional rights of mentally ill and mentally retarded citizens. Based on the ethos of the Fourteenth Amendment of the United States Constitution, the minimum moral standards' ruling ended generations of abuse to patients in Alabama's mental health institutions.[20]

Who were these poor souls who inhabited the state's asylums, and why were they there? When and why did the abuse start, how did it ultimately end, and through whose agency was it ultimately abolished? What happened that allowed Alabamians to become so complacent, so accepting of the asylums' horrendous policies. Who was to blame? Was it society, the legal system, state politics steeped in a history of inequality, the institutional superintendents, or in assigning culpability, should we look to some combination of all these variables?

This thesis explores the history of the abuse to the patients in Alabama's Mental Health Hospitals from 1860 to 1970. It addresses the social norms that encouraged the

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[19]The minimum standards also embraced the social, legal, and political issues concerning constitutional care v. custodial care, involuntary commitment v. deinstitutionalization, civil liberties of blacks v. white supremacy, and state rights v. federal judicial law, all grouped under the issue of economics.

[20]*"The Fourteenth Amendment of the United States Constitution," The Declaration of Independence and The Constitution of the United States*: with an Introduction by Pauline Maier (New York: Bantam Books, 1998), 83. Section 1.

abuse, the legal aspects that endorsed the abuse, the political forces that compound the abuse, and the medical and administrative policies of the superintendents and their staff that executed the abuse. It concludes by relating the events that lead to the landmark federal ruling in the Wyatt v. Stickney case that ended the abuse and guaranteed the patients their minimum moral rights.

CHAPTER II. SOCIAL ISSUES AND THE RIGHT TO "MORAL TREATMENT" FROM THE CIVIL WAR TO WORLD WAR I

Introduction

In the 1850s, the state envisioned its new asylum, the Alabama Insane Hospital, as an impressive facility catering to the needs of its mentally ill citizens. Philadelphia architects Sloan and Stewart, who had previously worked under the direction of Dr. Thomas Kirkbridge, superintendent of the Pennsylvania Hospital for the Insane, were employed to design the grand building. Located two miles east of Tuscaloosa, the new hospital would consist of a four story main building that would contain more than thirty large rooms. Its surrounding wings would be three stories high, and for the purpose of light and ventilation, each wing would have three sections connected by cross-halls of the

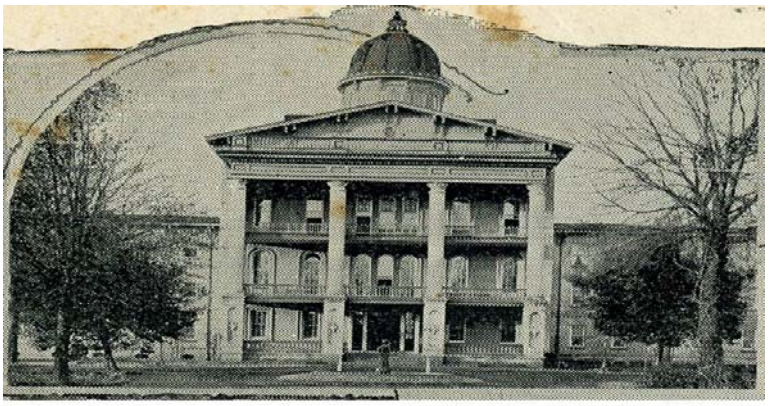

Figure 1. The *Biennial Report of the Alabama Bryce Insane Hospital, at Tuscaloosa, for the Years Ending 30th September 1895 and 1896,* (Montgomery, Ala.: Roemer Printing Company, State Printers and Binders, 1896).

same height. The two wings would consist of eighteen wards containing three hundred rooms that would house approximately four hundred patients. For social protocol, the architectural design would separate the male patients from the female patients. The women would live in the wards extending east from the administrative offices, while the men would populate the west wing. Each ward would have a dining room, parlor, bathroom, drying room, and water closet.[21]

By the end of the 1800s, the population of the asylum had grown beyond physical capacity for comfortable habitation. According to the hospital's annual reports, the reason for the asylum's high census was the fact that insanity was on the rise among the poor, a predisposition fate exacerbated by reproduction. Another reason, although only implied, for the overextension was the fact that the state appropriated funds to the asylum according to the amount of committed patients, and with the hospital always in need of funds, the hospital's administration found it fiscally difficult to refuse any request for admission. Gradually, as the asylum's quotas increased, the indigent patients were housed several to a room, overflowing into the halls, and eventually into the barns. When faced with a substantial number of patients of both races in one state hospital and with the new 1901 Constitution that cemented segregation, the Legislature had no alternative than to provide for its African-American citizens appropriations for a "separate but equal" hospital, an abandoned fort located at Mount Vernon, near Mobile. In 1922, the social

[21]Peter Bryce, "Second Annual Report of the Superintendent of Alabama Insane Hospital, from 20th Oct. 1861, to 20th Oct. 1862," *Annual Report of the Officers of the Alabama Insane Hospital, at Tuscaloosa, for the Year 1862* (Montgomery, Ala.: Montgomery Advertiser Book and Job Office, 1862), 28–29.

rejection of the “feebleminded” and the legal awareness of eugenics created a popular movement; consequently, the state allocated funds for the construction of a third institution, the Alabama “Home” for Mental Defectives in Tuscaloosa, adjacent to the Alabama Insane Hospital.

According to the asylum’s first superintendent Dr. Peter Bryce, who served from 1860 to 1892, and later resonated by the superintendents who succeed him, the efforts to administer medical aid to the state’s mentally ill was consistently hindered by inadequate state appropriations. Strapped with this burden, Bryce struggled to lay the groundwork for the development of Alabama’s mental health programs. While striving to surpass the conventional, medical standard of using restraining shackles in treating the insane, Bryce sought to incorporate moral treatment and occupational therapy into his treatment programs. Through occupational therapy, Bryce directed the hospital’s impoverished, white and black inmates to work the coalmines and farms. With the proceeds from the sale of the coal, cash crops, and animal products, Bryce was able to generate a positive cash flow, which provided means for the institution’s facilities and land holdings to grow at a substantial pace. The earnings also empowered Bryce to move beyond financial restraints and achieved a reputation as a competent and creditable administrator of a self-supporting institution.

By advocating moral treatment and a non-restraint policy and emphasizing the use of occupational therapy, Bryce built the foundation of his medical philosophy used for generations by subsequent superintendents. Occupational therapy came to entail light busy work for the literate white males and females and for all others, it denoted farm labor. After Bryce’s death, Superintendent James Searcy, 1893 to 1919, continued

Bryce's ethos of moral treatment and occupational therapy, and consequentially, acquired a new asylum and sixteen hundred acres of land in Baldwin County. Following Searcy's retirement, Superintendent William Partlow, 1919 to 1949, who also emulated Bryce's policies of moral treatment and occupational therapy, carried it to new heights, which contributed immensely to the growth of the institutions. Through the purchase of adjacent farmland and the construction of the Home for the Defectives, Partlow managed three asylums and farmland that covered over ten thousand acres. Due to their efforts and managerial successes, many respectable national social organizations cited the three Superintendents as progressive and, in many ways, leaders in the medical treatment of the mentally ill.

Such praise is problematic given the status of many of the patients Bryce and Partlwo supervised. Who exactly were they and why were they in the asylums? In the aftermath of the Civil War, with the state's economy severely challenged, the asylum's clientele, more commonly known as inmates, consisted primarily of white and black rural indigents, folks who had lost their land and had no financial means of support. Due to little food and inadequate hygiene, many had developed diseases feared to be hereditary or contagious. Some saw institutionalization as a means of isolating them from the larger population. The asylum also contained patients labeled as social misfits because of their addiction to tobacco, alcohol, and/or drugs, and consequently, were regarded as a liability and a humiliation to their families. Other patients were epileptics and "feebleminded," according to the language of the day, people who had been involuntarily committed by their families in order to eliminate embarrassing public behavior or to prevent reproduction. There were also the old and unwanted; several were spinsters or widows

whose mere existence placed a financial burden on their families. Regardless of their medical or social conditions, the majority came to the asylum as homeless. Consequently, as these indigent patients began to occupy the institutions as long-term residents, the superintendents' methods of moral treatment and occupational therapy quickly evolved into the plantation system of slave labor.

In retrospect, one may question whether the successive superintendents' methods of moral treatment and occupational therapy successfully treated the mentally ill, or did their methods simply exploit the patients, and in turn, enhance the superintendents' professional status and wealth? One could reasonably argue that the superintendents' methods were both "successful," by some measures, *and* exploitative. Although some appear to be more sincere than others were, the superintendents recorded in their annual reports their convictions, both ethically and professionally, as to how they sought to care and assist the mentally ill. The reports categorized the patients' characteristics, such as class, race and education. The reports noted how they purchased and provided modern medicine and machinery for curative treatment. The reports listed the patients' services ordered by the superintendents, such as daily meals, religious gatherings, and scheduled amusements. Finally, with the same 'matter-of-fact' tone, the annual reports listed the numerous additions to the facilities, the enormous quantities of cash crops produced by the inmates, and the enhanced growth of the hospitals' net worth.

Even more enlightening than the superintendents' annual reports were the patients' books and letters depicting the superintendents' actions with the descriptions of conflicting deeds and tales of abuse and neglect. These accounts chronicle how the asylum denied the patients their rights to receive medical treatment, food, privacy,

liberty, and equal rights. The stories expounded on crucial issues, such as the limited understanding of treatment for mental illnesses, the scarcity of staffing, the lack of state funding, and class and racial discrimination, which encouraged moral treatment containing elements of greed, white supremacy, class discrimination, and brutality. In addition, the inmates' stories illustrated how the institutions became a warehouse for custodial care. At the end of the twentieth century, when medical and legal professionals measured the superintendents' methods of moral treatment and occupational therapy against standards of modern times, they deemed the methods both medically and legally unacceptable.

Examined over the decades, one can detect important patterns and both continuity and change in the circumstances and procedures in place at the institutions. As easy as it may be to condemn those policies, it is it not important to entertain counterfactual circumstances. Had the hospital administrators rejected these indigents, who would have cared for them? Is it not possible they would have starved or otherwise come to harm? Did the problem of an inadequate staff excuse the institutions for providing only custodial services for the poor, the old, and the feeble? Close examination of the superintendents' annual reports and state legislation, along with the books, letters, and other evidence left behind by the inmates, reveals how and why generations of patients were abused and denied their minimum moral rights.

The Acts of 1852: The Establishment of the Alabama Insane Hospital

Act 5 of 1852 set forth the laws that established the administrative body and its duties in the operation of the Alabama Insane Hospital. The Act stated that the governor

was to nominate a seven member Board consisting of a president and six trustees and to submit the nominations to the Senate for approval. Chosen for their ability to manage a state asylum, the Board's duties entailed writing and publishing the by-laws and regulations of the institution, submitting an annual report to the Governor, attending monthly and yearly meetings, and hiring and firing the hospital's Superintendent. In conclusion, except for traveling expenses required for business transactions, the Board members were to receive no compensation for their services.[22]

As for the superintendent's responsibilities, the law stipulated that he had to be a physician who was to provide adequate treatment to the misfortunate. Section 11 stated that as a physician, he had to have an "unblemished moral character, an enlightened education, prompt business habits, and a humane, kindly disposition."[23] The law also required him to be married and to reside with his family in the institution's main complex. For a yearly salary of two thousand dollars, he was to serve an eight-year term. His responsibilities included hiring the necessary ratio of assistant physicians, nurses, and servants. He had the authority to direct and evaluate their performances, and if found unsatisfactory, he could discharge them. Finally, he was obligated to the Board and the state to maintain a smoothly operated institution. Hence, to keep abreast of his performance, the Board required the superintendent to submit a yearly report on his

[22]Alabama, *Acts of Alabama, 1851–1852* (Montgomery: Brittan and DeWolf, State Printers, 1852), 11–15. The president was to preside for six years, whereas the trustees' terms were on a rotating basis. Two trustees were to serve for two years, two for four years, and two for six years, and all subsequent appointments were to be for six years. Their contract stipulated that the president and two trustees had to live in Tuskaloosa [Tuscaloosa] County or an adjoining county and the other four trustees had to residue within the state. The Board could appoint a secretary and treasure and any other officers and agents that were necessary. In addition, they were bonded for receiving funds and securities from the state, the patients, and the patients' relatives.

[23]Alabama, *Acts of Alabama, 1851–1852*, 13.

administrative activities, such as the current census of the patients, their monetary needs, and the tally of all hospital expenses. After the Superintendent had submitted his report, the President would include it in the Board's annual report to the Governor who in turn would convey the information to the Legislature.[24]

The Act also listed the state's financial obligations to appropriate funds for the operation of the hospital's facilities and for the salaries of the staff, the counties' financial obligations of payment for services rendered to their residents, and the non-indigenous patient's obligations of payment to the asylum. Designated as a corporation, the state comptroller was to appropriate five percent of the total amount of the state revenue to the state treasurer in a fund for the Alabama Insane Hospital. The said fund was "declared to be applicable to the objects, uses and purposes of the said institution, and for creating and maintaining the same."[25] Once deemed insane by a probate judge, the indigents' respective counties were responsible for the patients' expenses, such as the cost for clothing, boarding, nursing, and medical treatment. County Commissions and probate judges were to send an annually census report of their county's insane persons and the funds to cover the indigents' expenses to the Secretary of State who would then transfer the money to the asylum. The persons requesting the admission of citizens, who were not

[24]Alabama, *Acts of Alabama, 1851-1852*, 10-19. The state approved Act 5 on February 6, 1852. The Board was to submit to the governor on the first Monday in December, an annual report of their proceedings and all monies spent during the year. *See also* Alabama, *Acts of the Legislature, and By-Laws for the Erection, Organization and Government of the Alabama Insane Hospital at Tuscaloosa* (Tuscaloosa: 1861), 6–8; Alabama, *Acts of Alabama, 1861* (Montgomery, Ala.: Shorter & Reid, State Printers, 1861), 25–31. Act 20, approved on February 8, 1861. The asylum's fiscal year began on October 20; Elizabeth Wisner, *Social Welfare in the South: From Colonial Times to World War I* (Baton Rouge: Louisiana State University Press, 1970), 113. As a part of their duty to their constituents, a common practice of the Legislature was to appropriate adequate funds for the patients' needs as requested in the Superintendents' report.

[25]Alabama, *Acts of Alabama, 1851–1852*, 11–12.

indigents had to provide a certificate from a respectable physician certifying the illness of the accused. In addition, the executor of the affiliate's estate had to provide a sufficient bond and had to pay three months charge in advance before admission. Concerning the priority of class preference for admissions, the law awarded the indigent insane precedence for admission over the paying patient, and any recently manifested case of insanity of either class would assume precedence over cases involving citizens who had been found to be insane for an extended period. [26]

While the Act of 1852 had established the laws outlining the administrative organization of the asylum and the state's obligations to the asylum, Supplementary Act 20 of the Acts of 1861, approved on February 8, 1861, five months before the asylum opened, described in detail the county's responsibilities for their residents' occupancy at the asylum. The Act stated that the county's probate judge, with or without a jury, had to investigate the case and call upon a respectable physician and any witnesses concerning the citizen's mental instability. At his discretion, if the judge deemed the indigent as insane, the Board of County Commissioners had to pay quarterly the incurred expenses of the indigent's boarding and lodging at the asylum. The law affirmed that if an indigent who had been in the asylum for three years and found to be incurable, the patient, at the superintendent's discretion, was to be collected by the residential county and delivered to its almshouse. The Act also addressed the issue of the paying patient. If the paying patient's executor discontinued payments on the hospital's services, after six months of nonpayment, the patient, now classified as an indigent, would become the respective county's responsibility. Finally, Section 12 of Act 20 pertained to the county's pledge to

[26]Alabama, *Acts of Alabama, 1851–1852*, 14–17. In 1852, the state had not listed the amount of the bond, but by 1870, it was $500.00.

the asylum's administration salaries. For reasons that will become apparent, it bears quotation in full:

> The annual salaries of the resident officers and treasurer of the hospital (said salaries not to exceed six thousand dollars for any one year) together with one-fourth the actual costs of boarding and lodging any indigent and pauper patients who have been received upon the order of any court or judge, (said fourth of the costs of boarding and lodging not to exceed one dollar a week for any one patient) shall be paid quarterly, on the first days of January, April, July, and October, by draft drawn by the treasurer of the hospital in their favor, countersigned by the president of the board of trustees.[27]

The drawback for the administration was that in order to receive the additional salary from the county, the patients had to have been civilly committed upon the order of the probate judge. Another stipulation was that if a paying patient became an indigent while in custody of the asylum, the county's obligation of supplement payment towards the staff's salary did not apply to that citizen. Nor did the law apply to epileptics or the feebleminded, simply because they were sane. Nevertheless, a more critical point existed. Since one-fourth or one dollar for each patient was the maximum the counties would pay as supplementary wages, an obvious observation made by the administration was that the weekly cost of maintaining the patient would have to be and would have to remain at four dollars.

Superintendent Peter Bryce: The Ethos of Moral Treatment

Acting upon noted mental health advocate and reform activist Dorothea Dix's recommendation, the Board of Trustees President, Dr. Reuben Searcy hired Dr. Peter Bryce as the asylum's first superintendent. With an impressive background, Bryce was

[27] Alabama, *Acts of Alabama, 1861*, vol. 1 (Montgomery, Ala.: Shorter & Reid, State Printers, 1861), 29–30, 25–31.

well qualified for the position. After graduating with honors from the South Carolina Military Academy (the Citadel) in 1855, Bryce had worked for two years at a local bank while studying medicine. In 1859, after receiving a doctorate of Medicine from the University of New York, he had traveled to France where he learned of the philosophy of moral treatment. Upon his return to the United States, he had accepted a position as assistant physician at the Insane Hospital of New Jersey, and a few months later, had transferred to South Carolina's Columbia State Mental Hospital. In 1860, upon notification of his appointment as Alabama's new superintendent, Bryce and his wife, Ellen, arrived in Tuscaloosa to oversee the opening of the new asylum.[28]

The Alabama Insane Hospital officially opened on July 6, 1861. According to the Board of Trustees' by-laws, the fiscal year commenced in October; consequently, the first annual report covered only three months of operation. Therefore, the second annual report, October 1861 to September 1862, not only listed the asylum's tabulations for the those twelve months, but included the first three months, July to September 1861, as well. Bryce's report consisted of summaries and tables listing the number of patients treated at the asylum, their alleged predisposing and exciting causes of insanity, and the patients' classification of occupation and payment. Bryce also added in the summary his definition of insanity, his philosophy on the moral treatment of the mentally ill, and finally, concluded with the treasurer's report.

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[28]Thomas McAdory Owen, *History of Alabama and Dictionary of Alabama Biography*, vol. 2 (Spartanburg, South Carolina: The Reprint Company, 1978), 244–245. Peter Bryce was born on March 5, 1834, at Columbia, South Carolina. He studied with Dr. Samuel Fair. Conferred upon his graduation from the University of New York was a certificate stating that he had attended the practice of the Medical and Surgical Wards for seventeen months**.** See also Katherine Vickery, *A History of Mental Health in Alabama* (Montgomery: Alabama Department of Mental Health, 1970), 31–36, 47–63. According to the asylum's by-laws, the Superintendent had to be married. As for the employees, their contracts required the assistant physicians and nurses, whose average age was 22, to be single and live on the premises.

The report began with Bryce's acknowledgement that the asylum had admitted approximately sixty-six patients, who upon entry had received two sets of garments, including a pair of shoes and a hat. According to Bryce's report, the patients' condition, their insanity, was "a departure, through disease of the brain, from the natural standard of thought and feeling of an individual…fallen below the standard of his own better self." He noted that the most "prolific predisposing cause of insanity was hereditary transmission." Bryce argued that the "essential requisites to recovery was a change of residence, restoration of physical health, pleasant and useful occupation … and healthful and innocent recreations and amusements."[29]

He concluded his report with the financial data. Of the sixty-six patients, Bryce noted that fifteen were paying patients and forty-six were indigents, including five criminal patients, who were county-funded. In the report, Bryce referred to the Act of 1861 that had established the county's responsibility for funding their respective residents' convalescence. Since one-fourth of the funding augmented the staffs' salaries, Bryce noted that only three-quarters of the county's payment covered the indigent's expenses. He wrote of his concern pertaining to the twenty-five percent shortage towards expenses, and hoped that the future of the hospital would not suffer due to this deficit. Bryce listed the income as approximately eleven thousand dollars from the state and two thousand dollars from other sources minus expenses of approximately eight-thousand dollars. With a previous balance of a little over two thousand dollars from the three

[29]Peter Bryce, "Second Annual Report of the Superintendent of Alabama Insane Hospital, from 20th Oct. 1861, to 20th Oct. 1862," *Annual Report of the Officers of the Alabama Insane Hospital, at Tuscaloosa, for the Year 1862* (Montgomery, Ala.: Montgomery Advertiser Book and Job Office, 1862), 12, 18, 14, 8–32.

months of operation prior to October, the current year showed a balance of approximately seven thousand dollars. It was an impressive report, considering that the state was in the midst of a Civil War.[30]

According to Katherine Vickery's *A History of Mental Health in Alabama*, during the War, Bryce had admitted both the mentally ill and the wounded Confederate soldiers to the hospital for medical care.[31] Possibly, due to the political upheaval during and after the war, the state forwent the publication of the 1862–1869 annual reports. However, in 1870, the state did publish Bryce's "Tenth Annual Report." Duplicating the format of the 1861–62 report, the report categorized the data as it had a decade before. First, he posted the tallies of the hospital's patients: fourteen white private patients, one hundred and sixty-nine white indigent patients, thirty-three colored indigent patients, and six white criminals. The census showed a reduction of seven percent in paying patients, but a three hundred percent increase of indigent patients in the ten-year period. He also stated that three babies, two black and one white, had been born during the year, but they were not included in the census.[32]

Bryce also added several new charts to his report. One new chart listed the patients' prior occupations.

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[30]Bryce, "Second Annual Report of the Superintendent of Alabama Insane Hospital, from 20th Oct. 1861, to 20th Oct. 1862," 8, 36-43. See also Alabama, *Acts of Alabama, 1861* (Montgomery, Ala.: Shorter & Reid, State Printers, 1861), 25–31.

[31]Katherine Vickery, *A History of Mental Health in Alabama* (Montgomery: Alabama Department of Mental Health, 1970), 35–36.

[32]Peter Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1870* (Montgomery, Ala.: W.W. Screws, State Printer, 1871), 8–11, 40.

TABLE I

Occupation of Patients Admitted from July 6, 1861, to October 1, 1870

	Men	**Women**	**Total**
Farmers, their wives and daughters	126	60	186
Mechanics, their wives and daughters	22	3	25
Laborers	58	32	90
Merchants, clerks, their wives and daughters	31	12	43
School boys and girls	5	2	7
Lawyers	6	0	6
Physicians and their wives	10	1	11
Ministers and their wives	11	1	12
Sailors	2	0	2
School-teachers and their wives	6	6	12
Printers	1	0	1
Soldiers	4	0	4
Spinsters	0	6	6
Domestics	1	10	11
None and unknown	51	96	147
TOTAL	334	229	563

Source*:* Peter Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1870* (Montgomery, Ala.: W.W. Screws, State Printer, 1871), 40.

He also added two tables showing the patients' predisposing conditions and forms of insanity. Because Bryce claimed, as he had in his 1861–1862 report, that insanity resulted from a predisposing diseased condition of the brain caused by hereditary, this data was an important element of his report. It also provides some insight to Bryce's perceptions and knowledge on insanity.

TABLE II

Alleged Predisposing Cause of Insanity of Patients Admitted from July 6, 1861, to October 1, 1870.

	Men	**Women**	**Total**
Hereditary transmission	105	57	162
Injuries	27	8	35
Intemperance	12	2	14
Typhoid Fever	7	4	11
Uterine Disease	0	9	9
Opium eating	1	3	4
Old age	0	1	1
Ill health	2	5	7
Epilepsy	4	4	8
Masturbation	3	0	3
Unascertained	171	134	305
Not insane	2	2	4
TOTAL	334	229	563

Source: Peter Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1870* (Montgomery, Ala.: W.W. Screws, State Printer, 1871), 40.

TABLE III

Form of Insanity of Patients Admitted from July 6, 1861, to October 1, 1870

	Men	**Women**	**Total**
Acute mania	61	43	104
Chronic and periodic mania	63	44	107
Epileptic mania	19	6	25
Hysterical mania	0	6	6
Monomania	52	23	75
Melancholia	30	26	56
Delirium	5	0	5
Dementia	54	47	101
Paralytic dementia	6	1	7
Imbecility	39	26	65
Idiotcy	3	5	8
Not insane	2	2	4
TOTAL	334	229	563

Source: Peter Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1870* (Montgomery, Ala.: W.W. Screws, State Printer, 1871), 41.

Drawing from his past medical studies and experiences at the asylum, Bryce wrote prolifically on his beliefs concerning the patients' methods of treatment. The superintendent incorporated standard medications in his treatment procedures and stated that the latest therapeutic medicine, hydrate of chloral had been given to the patients with favorable results. However, he argued that the medical professional's use of conventional methods of restraints was counterproductive and ineffective in curing the insane, and claimed that the best curative method of treatment for the insane was moral treatment. In

the section titled, “Moral Treatment of the Insane,” Bryce described his philosophy of moral treatment:

> It seems, too, to have been forgotten or discredited in many quarters, that dungeons, cells, chains, cribs, shower baths, and other appliances of cruelty, have long since been abandoned in the scientific treatment of insanity; and that, combined with judicious medication, systematic kindness and undeviating candor, with firmness, are alone the great moral agents upon which the humane and enlightened physician relies for success.[33]

Bryce indicated that he planned to implement his methods of moral treatment at the asylum. He also added rules condemning physical abuse committed by the staff to the patients, an action he would not tolerate. According to Bryce, all employees had to exhibit courtesy, kindness, and respect toward the involuntary committed inmates. To assure obedience to his commands, Bryce created disciplinary fines for each staff violation and deducted the money from the employee’s monthly salary.[34]

On a more positive note, Bryce described his other components of moral treatment, which included religious worship, reading, and amusements. He wrote of the patients’ daily morning religious services that consisted of Bryce reading to the inmates a chapter from the Bible, singing a hymn accompanied by the organ, and finally, citing a prayer. With an average of seventy-five patients of various denominations attending the exercises and with few being Episcopalian as himself, he thought it necessary to arrange for local ministers of different denominations to preach on the Sabbath. He expounded on the benefits of reading and the patients fortunate in having a well-stock library of books

[33]Bryce, “The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital,” 10, 10–14.

[34]Bryce, “The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital,” 12–13. Bryce stated that fines as much as seven percent were deducted from the staff’s salary and total over $500.00 for the year.

and newspapers. He also stressed how amusements were a crucial element of moral treatment, that such diversions "were indispensable … important agents in restoring lost or impaired mental health," and emphasized how recreation would always be an important component of his moral treatment.[35]

Bryce ended his 1870 report with the hospital's financial data. According to Bryce, the asylum had an operational expense of approximately forty-six thousand dollars, a four hundred percent increase in expenses since its opening. However, the weekly per capita costs remained at four dollars. In his closing remarks, he grievously noted that the state, the body that collected the funds for the indigents' expenses from the counties, was delinquent in paying the hospital the patient's weekly allotment. Possibly, to some, the delay in payment could somewhat be understandable in an agriculture state that had lost a major war and a practically dissolved economic structure, but not to Bryce. In an ominous development, at the end of the year the state decided to acknowledge its delinquencies and to change its policy of supporting the asylum. With new legislation, the state mandated that the state's annual appropriation for supporting the hospital would not exceed forty thousand dollars.[36]

Three years later, Bryce commented in his annual report of the difficulties the hospital encountered with the inadequate appropriations of forty thousand dollars. He argued that Alabama's funding was considerably lower than the national average, even

[35]Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital," 32, 31–32.

[36]Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital," 28–30, 43, 49. Coincidently, the maximum allowed by the Acts of 1861 for the county ratio on payment of salaries. Bryce had calculated that the counties were providing only $3.44 per capita. In addition, by beginning late in payments, according to Bryce, the institution had also lost the interest it could make on the funds' deposits.

lower than its sister states. To strengthen his argument, he included a table that showed the appropriations of other southern asylums. Furthermore, he complained that the inmates who were uncontrollable or incurable had not been removed from the hospital by their respective counties, at which time they would be sent to the county almshouses. Bryce claimed that their presence was an unnecessary financial burden for the asylum.[37]

TABLE IV

State and Names of Asylums

STATES AND NAMES OF ASYLUMS	Average No. of Patients	Total Annual Expenditures	Annual Cost of Patient
Virginia – Eastern Lunatic Asylum	233	$63,607.45	$272.99
Virginia – Western Lunatic Asylum	340	68,960.27	202.82
Virginia – Central Lunatic Asylum	187	42,457.21	227.04
Kentucky – Eastern Lunatic Asylum	555	129,915.59	234.08
Kentucky – Western Lunatic Asylum	317	65,470.13	206.53
Tennessee – Hospital for the Insane	362	73,300.23	202.48
North Carolina – Insane Asylum	239	70,903.15	296.66
South Carolina – Lunatic Asylum	289	89,285.49	308.94
Georgia – Lunatic Asylum	420	121,371.03	288.97
Mississippi – Lunatic Asylum	300	93,600.00	312.00
Louisiana – Insane Asylum	165	58,790.00	356.30
Texas – Lunatic Asylum	100	64,771.01	647.71
Alabama – Insane Hospital	312	60,841.20	195.00
TOTALS	3,819	$1,003,272	$262.70

Source: Peter Bryce, "Thirteenth Annual Report of the Superintendent of the Alabama Insane Hospital, October 1873," *Thirteenth Annual Report of the Alabama Insane Hospital, October 1873* (Montgomery, Ala.: Arthur Bingham, 1873), 14.

[37]Peter Bryce, "Thirteenth Annual Report of the Superintendent of the Alabama Insane Hospital, October 1873," *Thirteenth Annual Report of the Alabama Insane Hospital, October 1873* (Montgomery, Ala.: Arthur Bingham, 1873), 14.

In 1875, as the Legislature wrote a new constitution, it again addressed its responsibility for providing for the asylum. The state passed Act 156, which transferred the financial responsibility of the indigents from the county to the state, which in turn terminated the supplementary salaries for the staff. The new constitution represented a major setback for Bryce, for now his only source of major income was the allocated appropriations for the hospital's census and the sum was not to exceed four dollars a week for each indigent, which included boarding, clothing, and lodging. To make matters worse, the salaries of all employees and the ordinary repairs to the facilities were to fall within the four-dollar appropriation as well.[38] Unforeseen by Bryce was the fact that the state's history of delinquency in making payments to the asylum would not be diminished by the new constitution, but would remain a perpetual problem for generations to come.

Plantation Labor as "Occupational Therapy"

Bryce accentuated the medical benefits of his implementation of moral treatment in his 1875 annual report to the Board and compared the asylum's level of expertise in the treatment of insanity to the best of the nation's hospitals. By following the tenets of his moral treatment program, he claimed to have reduced the use of physical restraints to a minimum, only rarely having to restrict the movements of the inmates "by seclusion in their rooms or confinement of their hands."[39] In the 1881–1882 biennial report, he wrote

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[38]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1875-6, held in the City of Montgomery, commencing December 28th, 1875, Together With The New Constitution* (Montgomery, Ala.: W.W. Screws, State Printer, 1876), 275. The payments were to be paid quarterly by the state.

[39]Peter Bryce, "The Fifteenth Annual Report of the Superintendent of the Alabama Insane Hospital," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1875* (Montgomery, Ala.: W.W. Screws, State Printer, 1871), 20.

that all "mechanical restraints had been abolished, although occasionally a stout suit of canvass is placed upon those who persistently destroy or remove their clothing, and it may be necessary to confine to his room a very excited and dangerous patient, for a short while … but these expedients are seldom resorted to"[40] Finally, two years prior to his death, Bryce noted in his 1889-1890 biennial report that "not a vestige of restraining apparatus of any kind is to be found about the premises, nor has there occurred a single case in the wards of the hospital, which seemed to justify or require its use."[41]

Closely allied to his argument of non-restraint was his approval of occupational therapy. Although Bryce acknowledged administering some drugs, such as bromide of potassium, hydrate of chloral, and the herb belladonna to his patients, he firmly believed that the core of all mental illnesses had a pre-existing physical basis. Therefore, in order to be effective, he postulated that the doctors had to focus on combating the patients' physical problems, a process accomplished with occupational labor. If not put to work, Bryce warned, then a life of idleness would destroy what little mind a patient had, and more importantly, "without occupation our system of non-restraint would be a failure."[42] Yet, to be more exact, Bryce should have written that without non-restraints, his system

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[40]Peter Bryce, "Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending 30 September, 1881 and 1882," *Biennial Report of the Alabama Insane Hospital, at Tuskaloosa, for the years ending 30th September 1881 and 1882* (Montgomery, Ala.: Allred and Beers, State Printers, 1882), 15. The canvass suit was a straitjacket.

[41]Peter Bryce, "Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," *Biennial Report of the Alabama Insane Hospital, at Tuscaloosa, for the years ending 30th September, 1989 and 1890* (Montgomery, Ala.: The Brown Printing Co., State Printers and Book Binders,1890), 19.

[42]Bryce, "Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," 21–22. The three drugs that Bryce used are still used today. Potassium bromide is an anti-convulsing medication used to control seizures in epileptics. Although habit forming, hydrate of chloral is used for insomnia. Belladonna produces relief from spasms of the gastrointestinal tract and the bladder.

of occupational therapy or plantation system of farm labor would be a failure. For obvious reasons, it would be difficult for the patients to work in harmony if they were restrained. In addition, Bryce implied that occupational therapy provided the insane with stability, security, and peace; therefore, it was a necessary part of their rehabilitation. According to Bryce, the continuity of farming was the indigents' salvation for survival. Ironically, farming had created most of the patients' problems of economic deprivation, social ostracism, and poor health.

Published in 1918, historian U. B. Phillips' *American Negro Slavery: A Survey of the Supply, Employment and Control of Negro Labor as Determined By The Plantation Regime* argued that the plantation system was an example of the South's heritage, exemplifying cultural and regulated class structure. Phillips described it as a method of "task" labor, "labor of overseers, carpenters, cooks, nurses, and plow-hands performed under the skilled management of the plantation owner."[43] Bryce knew that in order to operate the asylum and its various farms it would require an array of laborers such as overseers, carpenters, cooks, and nurses. It would also require a large number of plow-hands to maintain the facilities and to grow the crops, all managed under his skillful supervision. Consequently, Bryce claimed that it benefited the chronically ill to participated in occupational therapy. As shown in his 1870 report, the patients were actively participating in the operation of the institution, even when the institution was receiving additional income from the counties.

[43]U. B. Phillips, *American Negro Slavery: A Survey of the Supply, Employment and Control of Negro Labor as Determined By The Plantation Regime* (New York: D. Appleton and Company, 1918), 261–290.

TABLE V

Total Number of Days' Work Done by Patients in the Several Departments

	Men	**Women**
Bakery		156
Cooper-shop	60	
Carpenter-shop	350	
Dairy	501	396
Garden (flower)	297	196
Farm and Garden	4590	27
Kitchen	655	
Laundry		833
Mangling-room		704
Machine-shop	290	
Mill	210	
Paint-shop	150	
Printing-office	10	
Sewing-room		1687
Stables	730	
Shoe-shop	630	
Upholstery	300	40

Source**:** Peter Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," *Annual Report of the Officers of the Alabama Insane Hospital at Tuskaloosa, for the Year 1870 (*Montgomery, Ala.: W.W. Screws, State Printer, 1871), 48.

Bryce acknowledged in his annual reports that he had to confront repeatedly the problem of inadequate financial support from the state, and therefore, had no alternative but to seek additional means to support the hospital. In his 1876 annual report, Bryce stated that the three hundred acres owned by the Hospital contained an unlimited supply

of gas-producing coal.[44] Within two years, Bryce supervised the patients' construction of a tramway from the hospital to the coalmines. The staff supervised the patients' work in the mines, and Bryce sold the coal to the University of Alabama and the city of Tuscaloosa at a profit of two dollars per ton.[45] In 1889, the administration, without obtaining additional money from the state, supervised the patients as they made major improvements to the hospital, such as installing telephones throughout the institution, placing a seventeen thousand gallon iron water tank in the attic of the Center building, and building a new amusement hall that had a seating capacity for three hundred patients.[46]

According to Bryce's annual reports, the patients' employment served a dual purpose: it supplied the fiscal means in which to operate the hospital and it had a remedial effect upon the patients. In 1880, Bryce stated that seventy percent of the male inmates and eighty-six percent of the females of both races worked. In addition, since the process of chopping and picking cotton required a large quantity of unskilled manual labor, Bryce found that occupational therapy could also apply to the labor of the asylum's children.[47] In his 1889–90 report, he noted that seventy-five percent of the men and

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[44]Peter Bryce, "The Sixteenth Annual Report of the Superintendent of the Alabama Insane Hospital," *Sixteenth Annual Report of the Alabama Insane Hospital at Tuskaloosa, October, 1876* (Montgomery, Ala.: W. W. Screws, State Printer, 1876), 33.

[45]Peter Bryce, "The Eighteenth Annual Report of the Superintendent of the Alabama Insane hospital," *Eighteenth Annual Report of the Alabama Insane Hospital, at Tuskaloosa, October, 1878* (Montgomery, Ala.: Barrett & Brown, Steam Book and Job Printers and Binders, 1878), 46.

[46]Bryce, "The Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," 17–19.

[47]Peter Bryce, "The Nineteenth Annual Report of the Superintendent of the Alabama Insane Hospital," *Nineteenth Annual Report of the Alabama Insane Hospital at Tuskaloosa, October, 1880*, (Montgomery, Alabama: Barrett & Brown, Steam Printers and Book Binders, 1880), 23.

ninety percent of the women worked in every department of the hospital, whether inside the hospital or on its extensive farms. Although it is questionable whether the required labor met the basic needs of medical treatment for the inmates, it was true that occupational therapy did add extensively to the asylum's cash flow by marketing the farms' animal and vegetable produce and selling its cash crops, such as cotton. His 1889-1890 report posted a net profit from the farm of nineteen thousand. Bryce wrote, "By far the best and safest work I have ever found for the average insane man is moving soil in a wheel-barrow."[48]

"Separate but Equal"

During and shortly after the Civil War, the layout and size of the asylum had diverted the problem of desegregation; the six wards on the first floor housed the black patients and the second and third floors contained the white patients. However, during Reconstruction, as the asylum became a refuge for the poor of both races, Superintendent Bryce found it increasingly difficult to find the space to discreetly separate the two races. By 1870, he noted that supplementary appropriations from the Legislature for additions to the hospital's wings and for the construction of a separate facility for the hospital's black patients were crucial if the asylum was to continue servicing African-Americans. Abiding by Bryce's requests, the state issued supplemental appropriations in 1878, for the

[48]Peter Bryce, "The Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," 17, 16–19, 22–23.

construction of a Lodge for the African-American women and two years later, allocated money for an additional Lodge for the African-American men.[49]

However, by 1881, new admissions for the black insane had become unobtainable due to the growing requests from white Alabamians to admit their kin. Again, faced with the problem of overcrowding, the Alabama General Assembly, under the direction of Governor Rufus W. Cobb, appropriated one hundred thousand dollars for the construction of an additional building. However, instead of constructing a new building, the administration added wings to both the east and west ends of the original structure.[50]

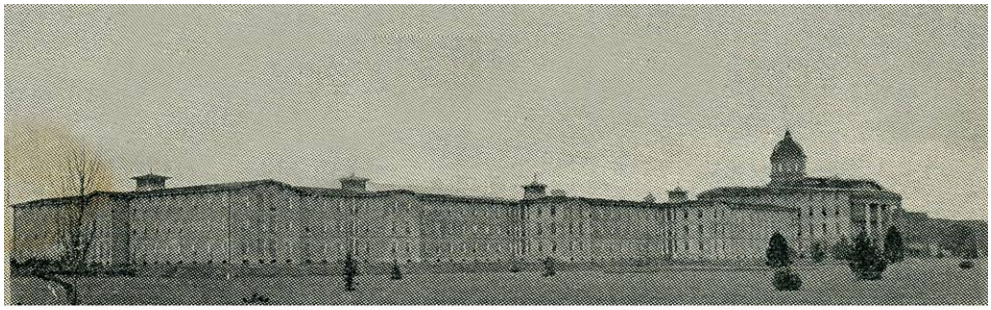

Figure 2. *Biennial Report of the Alabama Bryce Insane Hospital, at Tuscaloosa, for the Years Ending 30th September, 1895 and 1896* (Montgomery, Ala.: Roemer Printing Company, State Printers and Binders, 1896).

Finally, in 1888, to Bryce's delight, the House of Representatives allocated money for an Annex, a small building adjacent to the main complex, for the asylum's African-American patients. Yet, this allocation was not a gesture of response or concern

[49]Bryce, "The Tenth Annual Report of the Superintendent of the Alabama Insane Hospital, Tuskaloosa, Ala., 1st October, 1870," 8–31.

[50]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1881* (Montgomery, Ala.: Allred & Beers, State Printers, 1881), 27–28. Act No. 29.

for Bryce's problem of overcrowding or for the comfort of the black inmates; instead, it was a gesture of necessity because of the growing concern of the state over desegregation. In 1890, the hospital's report listed forty-five paying white patients, seven hundred and forty-five white indigents, two hundred and thirty-one black indigents, nineteen white criminals and ten black criminals. With a census of approximately one thousand patients of which approximately twenty-five percent were African-Americans, the asylum again encountered the continuity of overcrowding and desegregation.[51]

In 1891, the Alabama Legislature addressed the problem of desegregation throughout the state as well as at the state asylum with its "Separate but Equal Accommodation Bill." Sheldon Hackney's *Populism to Progressivism in Alabama* asserts that with the new law the lawmakers shot themselves in the foot, so to speak. The majority of black Alabamians lived on farms, many were without wages, and what little work they could obtain was primarily in the form of sharecropping. The state mental hospitals, faced with the increase of poverty and disease among the African-American tenant farmers and sharecroppers, received an endless flow of requests for admissions of family members. Hackney asserts that since neither the black patients nor their families could afford to pay for the medical accommodations, the liability to provide funds for the indigents' upkeep, compounded with the additional costs of separate facilities and staffing, fell upon the state.[52]

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[51]Peter Bryce, "The Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," 11. *See also* Katherine Vickery, *A History of Mental Health in Alabama* (Montgomery: Alabama Department of Mental Health, 1970), 51–52.

[52]Sheldon Hackney, *Populism to Progressivism in Alabama* (Princeton, N. J.: Princeton University, 1969), 33–47. *See also* Department of Labor, *Division of Negro Economics* (Washington, D.C.: Government Printing Office, 1919). In the Black Belt counties, where the majority of the state's African-Americans lived, many were starving. In an attempt to halt the crisis, the federal government had sent

Voices of the Inmates

By the latter part of the nineteenth century, to the delight of the Board of Trustees, the governor, and the Legislature, Bryce had successfully established and sustained a mental institution regarded by financial experts as one of the best managed in the nation. In addition, medical experts and civic organizers praised Bryce as a pioneer in psychiatry and the forerunner for the establishment of moral treatment and occupational therapy in the care of Alabama's mentally disabled. As a result of his introduction of the unprecedented moral treatment of the non-use of shackles, straitjackets, and other mechanical restraints and his enforcement of strict discipline among his staff in their behavior toward the patients, many perceived him as a humanitarian and an asset to the insane.[53]

According to former patients, however, Bryce's methods of moral treatment and occupational therapy were not beneficial, but were acts of moral and mental degradation. Through their books and letters, the inmates who were neither insane nor destitute described acts of abuse, such as the denial of food and confinement to cells; acts condoned by Bryce and committed by his staff.

One of the inmates who contradicted Bryce's positive contributions to the mentally ill was Rev. Joseph Camp, an educated, middle-class Methodist minister who

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employees of the United States Department of Agriculture from Washington down to Alabama to distribute commodities to the poor.

[53]Vickery, 47. By 1892, Dr. Peter Bryce had attained national recognition and had the complete confidence of the people of the state of Alabama. Nationally known because of his system of absolute non-restraint of mental patients, he had "abolished all mechanical restraints of patients such as strait jackets, camisoles, bed straps, crib beds, and other like appliances known as restraining apparatus." Bryce served as president of the Medical Association of Alabama and of the American Medico-Psychological Association (later the American Psychiatric Associate). He was also the First Vice-president of the Medico-Legal Society of New York.

was addicted to nicotine. Bryce had recommended to Camp's wife and son-in-law that due to Camp's habits of chain-smoking and sleeping only six hours a night, accompanied with his recent weight loss, that he should be committed to the asylum. Admitted on May 20, 1881, Camp's incarceration lasted for five months and twenty days. Shortly after his release from the hospital, Camp wrote and published *An Insight into an Insane Asylum* in which he described his encounters with Superintendent Bryce. Because it provides insight into the daily operation of the Alabama Insane Hospital at the prime of Bryce's administration and his application of moral treatment and occupational therapy, the book is enlightening.[54]

Camp described his first encounter with the asylum's personnel as one of dismal and abusive treatment. He stated that upon entering the hospital, the staff immediately separated him from his family and placed him in a room that contained a doorway with two connecting doors. Camp wrote that the inner door allowed one some air, light, and privacy, but once the staff, from the hallway, locked the outer door, the room transformed into a cell that generated a stifling environment with a sense of punishment. Later that evening, Camp stated the staff brought him a tin cup of tea, a piece of bread, and a tin plate of molasses; a meal he described as one of a tenant farmer. According to Camp, the meal was a symbol of implied class degradation, and when combined in unison with the room, it created an aura of servility.[55]

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[54]Reverend Joseph Camp, *An Insight into an Insane Asylum (*Munford, Alabama: Published by Author, 1882), 12–19, Alabama Collection, Special Collections, Ralph B. Draughon Library, Auburn University, Auburn. Camp was born August 2, 1811 in Jackson County, Georgia. He joined the Methodist Church on October 1825, became a Deacon in Talladega in 1854, and an Elder in 1859. The family was worried about Camp because he had recently lost fifty pounds.

[55]Camp, 24–25.

A few days later, when he encountered Bryce, Camp questioned him as to how he could diagnose him as being ill without first administering an examination. According to Camp, Bryce responded that during their introduction, their less than two-minute conversation, he had examined Camp and had formulated his opinion. As the days passed and as Camp observed Bryce on his rounds, he wrote, "Bryce has more power and apparently less to do than any king or potentate on earth, for all he does is to pass through the various wards twice a week—Tuesday and Friday mornings at nine o'clock."[56]

Assisting Bryce on his rounds was W.C. Perkins, the secretary; a Mr. Davis, the apothecary; and B.L. Wyman, a young physician who Camp classified as one who treated his patients with humility and respect. While liking Wyman, Camp disliked Perkins. Camp recalled an occasion when he asked Perkins for some paper in order to write to his family. Instead of providing him with the paper, Perkins had him transferred to the ward's cross-hall. The cross-hall, the area referred to by the patients as the dungeon, contained cages furnished with straw mattresses and wooden boxes substituting for slop jars. Questioning why he had been sent to the cross-hall, Perkins informed Camp that he had broken one of the unwritten rules, he had asked for something. Traditionally, when this occurred, Perkins claimed the administration would deny the request and would send the patient to the cross-hall where they were fed only bread and molasses for meals.[57]

According to Camp, throughout his stay, depending upon whether it was punishment or reward, he was moved to various wards: ward 2 (the best ward and the one that all visitors were allowed to tour), 3, 6, 9, 8 (for the maniacs), and to the cross-hall

[56]Camp, 39.

[57]Camp, 37–43.

(the dungeon).[58] Another incident of punishment he recalled concerned his birthday. Bryce had informed Camp that in celebration of his upcoming seventieth birthday, the hospital's cook would bake Camp a very special cake and all would join in his celebration. When the day arrived, there was no birthday cake or celebration. Camp learned from the staff that Bryce and his wife had gone to Virginia for a short holiday. To compound the personal insult, when his family arrived for the anticipated celebration, the staff denied Camp the right of visitation.

Camp devoted a considerable portion of his book to complaints about the lack of food at the asylum. For example, he stated that although there was an abundance of watermelons from the farms, he never had the pleasure of tasting one, although, he did admit that occasionally the patients had a treat of cantaloupe or a meal consisting of okra, grits, peas, and beef. Yet, for the most part, supper consisted of bread, molasses, and a cup of tea. Camp stated that he found it painful to "starve amidst plenty."[59] Bryce listed the daily meals in his 1881–1882 report, and according to Bryce's table, Camp's complaints were in many instances legitimate.

[58]Camp, 31–81.

[59]Camp, 28.

TABLE VI

BILL OF THE FARE

The following is, as near as possible, a Bill of the Fare furnished the patients at each meal:

BREAKFAST

SUNDAY. Coffee, Beefsteak, Bread, Hominy.	THURSDAY. Coffee, Beef-stew, Bread, Hominy.
MONDAY. Coffee, Ham or Bacon, Bread, Hominy.	FRIDAY. Coffee, Fresh Fish or Mackerel, Bread, Hominy.
TUESDAY. Coffee, Beefsteak, Bread, Hominy.	SATURDAY. Coffee, Fried Liver, Bread, Hominy.
WEDNESDAY. Coffee, Tripe or Hash, Bread, Hominy.	

DINNER

SUNDAY. Milk, Roast Beef, Vegetables, Pickles, Bread, Pie.	THURSDAY. Milk, Poultry, Vegetables, Bread Pudding.
MONDAY. Milk, Roast Mutton, Vegetables, Rice, Bread.	FRIDAY. Milk, Bacon, Vegetables, Fish, Bread.
TUESDAY. Milk, Soup, Pork, Vegetables, Bread, Fruit.	SATURDAY. Milk, Soup, Roast Beef, Vegetables, Bread, Fruit, Pies.
WEDNESDAY. Milk, Roast Beef, Vegetables, Rice, Bread, Pickles.	

SUPPER

SUNDAY. Tea, Bread, Butter, Molasses, Cheese.	THURSDAY. Tea, Rolls, Butter, Molasses.
MONDAY. Tea, Biscuits, Marmalade, Butter.	FRIDAY. Tea, Biscuits, Butter, Molasses.
TUESDAY. Tea, Rolls, Butter, Strawberries.	SATURDAY. Tea, Bread, Butter, Soft Ginger-bread, Molasses.
WEDNESDAY. Tea, Bread, Butter, Crackers, Molasses.	

Source: Peter Bryce, "Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending 30 September, 1881 and 1882," *Biennial Report of the Alabama Insane Hospital, at Tuskaloosa, for the years ending 30th September, 1881 and 1882* (Montgomery, Ala.: Allred and Beers, State Printers, 1882), 38.

Rev. Camp also recalled daily life at the asylum and Bryce's notions of occupational therapy and moral treatment as ambiguous in many ways. Camp asserted that during his convalescence he was not required to work, although the mainstream of patients did work under the supervision of paid overseers. Obviously, according to Camp, some patients could perform better than others could; therefore, they performed jobs that required more responsibility, such as aides who cared for other patients. The hospital staff also assigned the physically stronger inmates to work in the coalmines or on the construction of the new wards. The degrading jobs, such as custodians or farmhands, were assigned to certain classes and races of inmates.[60]

On a lighter note, there were elements of Bryce's moral treatment that Camp did enjoy. One was the hospital's recreational activities: a dance on Tuesday, games on Friday, and singing every Sabbath evening. He also enjoyed the asylum's library. Although Camp wrote that he found it puzzling that a hospital, containing very few patients who could read, housed an excellent library and received newspapers from all parts of the United States and Europe.[61]

Camp also commented extensively on the asylum's claim of spirituality, but found it confusing because he felt the asylum lacked spirituality. While noting that there were Catholics, Presbyterians, Baptists, and Methodists inside the hospital, Camp proclaimed that he sought, but could not find the presence of God. Camp reasoned that part of the problem was the lack of religious protocol, such as blessings before the meals or nightly prays. Equally troubling for him was the fact that the staff had confiscated his

[60]Camp, 51–55, 72–96. Camp refers to Bryce's first patient, the Confederate soldier by the name, Weed of Talladega County. Weed was in charge of the dining room on Ward #8.

[61]Camp, 50, 79.

Bible during his admission. Grudgingly, he had retaliated days later by preaching for hours in his room, and in return, the staff had responded by denying him the right to attend church services. During his six-month stay, the staff only permitted him to attend three sermons. Camp concluded his book with a call for a chaplain to aid the ill, and the assertion that his disdain feelings for the asylum's administration and staff had prompted him to publish his book, "in order to let the citizens of Alabama know how lame are the laws that govern this institution." [62]

In 1890, shortly before Bryce began to suffer from Bright's disease, an ailment that eventually led to his death, Bryce wrote on the attitude of his nine hundred patients:

> [T]he industry, cheerfulness, and spirits of contentment which are everywhere apparent; and the absence of all complaints of ill treatment or neglect of any kind, as well as the universal feeling of confidence and respect evened for both officers and nurses, are some of the fruits of this system which we would not willingly forego."[63]

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[62]Camp, 31, 53–56, 104-106. Camp left the hospital on November 10, 1881. See also Vickery, 47–63. For years, Bryce had studied the trials of the criminally insane and in 1881, was summons as an expert witness in the trial of Charles Guiteau, the assassin of President Garfield. He had also been a member of the Commission of Lunacy established by the Alabama General Assembly for studying the custody and trial of the criminally insane. Bryce was an active member of the Commission of Lunacy, established by the Alabama General Assembly. In 1882, the University of Alabama recognized Bryce as one of the state's outstanding men and conferred on him a LL.D. degree. Besides having a reputation as one well versed in psychiatry and law, Bryce was also known by a selective few as a successful businessman. After his death in 1892, Bryce's will validated that he had acquired extensive shares of various stocks and bonds. It read that he owned stock in three railroads and seven business and manufacturing companies, and as one of the organizers and bondholders of the First National Bank of Tuscaloosa, he held bonds at the First National and in banks located in three cities in Massachusetts. In addition to the bonds, Bryce, along with several business and political leaders such as B. B. Lewis, president of the University of Alabama from 1878 to 1885; Senator Robert Jemison; Judge H. Somerville; and T. W. Palmer, bought an array of businesses and properties, including ten thousand acres of mineral lands that was later sold to the Tuscaloosa Coal, Iron, and Land Company; Peter Bryce, "Last Will and Testament," Tuscaloosa: County Probate Records, Alabama Department of Archives and History, Montgomery; Ellen Bryce, "Last Will and Testament," Tuscaloosa: County Probate Records, Alabama Department of Archives and History, Montgomery, Alabama. When Ellen died during the Depression, her net worth of stocks, bonds, and property was estimated to be worth approximately a quarter of a million dollars. Bryce was 58 years old when he died of Bright's disease, an aliment of the kidneys. Bryce requested to be buried on the west side of the grounds; the site is marked by a monument eight feet high.

[63]Bryce, "The Biennial Report of the Superintendent of the Alabama Insane Hospital, for the years ending September 30, 1889 and 1890," 20.

In this environment of "cheerfulness," he made an exception to his policy of limiting admissions of the criminally insane to the asylum. He admitted Miss Andrew Moore Sheffield, a single, forty-one-year-old chloral hydrate addict, accused of attempted arson. Both her half-brother, a probate judge and her father, a prominent Civil War veteran and businessman in north Alabama, desired a less embarrassing alternative than jail for their family; thereby, instead of having her tried as a criminal, they had her involuntary committed on grounds of insanity.

Sheffield's only recourse for seeking freedom from her incarceration was to write letters to people of authority. In her letters, she identified herself as guilty as an arsonist, but not, as one insane. With these letters, John Hughes' *The Letters of a Victorian Madwoman* documents Sheffield's thirty years of incarceration at the Alabama Insane Hospital. Hughes states that Sheffield was an educated woman, who knew that she had been denied due process and who consistently advocated for her civil rights in endless letters to Alabama governors and the asylum's superintendent, the one person who had complete control over her freedom. Shortly after she had entered the asylum, Bryce died and Superintendent James T. Searcy became the recipient of Sheffield's letters in which she repeatedly requested a trial and her transfer from the asylum to the state penitentiary. Usually infuriated by either a governor's refusal to intervene on her behalf or Searcy's repeated denials to transfer her to the state prison, Sheffield sought revenge by informing each new governor of her disapproval of the past governor and of Searcy's methods of moral treatment. Nevertheless, her letters are worth mentioning because they provide detail information on various degrees of abuse she received as a woman of substantial

social and financial means. Although later, she became a ward of the state after being abandoned by her family. Equally important, her letters provide the reader with an insight into the lack of her legal and moral rights under the Fourteenth Amendment during her life-term of involuntary commitment. [64]

As one reads her letters, one can detect severe mood swings. At times, she was docile, expressing either remorse for her fits of bad behavior or appreciation for some kind act performed by the staff. In a letter dated July 1897, Sheffield thanked Searcy profusely for letting her work for the nurses. Along with the other white women, Sheffield would create fancy pieces of sewing that the aides sold to Tuscaloosa's residents, a labor that provided the patients as well as the staff with a small income. According to Searcy's "Biennial Report of 1893 and 1894," while prohibited by social convention to place the white women in the fields with white men and African-American men and women, he could encourage the white women to sew and garden, to keep busy, as long as the labor was "slow, orderly, and productive."[65]

At other times, the letters indicated a hopeless woman filled with rage. Her May 14, 1898, letter to Governor J. F. Johnston proclaimed that due to an outburst of anger, the staff had placed her "on the backwards with the incurably insane and epileptics … an attempt by Searcy and the nurses to control her." According to Sheffield, the backwards

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[64]John S. Hughes, ed, *The Letters of a Victorian Madwoman* (Columbia: University of South Carolina Press, 1993), 44. Although Sheffield was also a patient under Bryce and Partlow's administrations, she was predominately under Searcy's supervision during her incarceration.

[65]James Searcy, "Biennial Report of the Superintendent of the Alabama Bryce Insane Hospital, for the Years 1893 and 1894, each ending September 30th," *Biennial Report of the Alabama Bryce Insane Hospital at Tuscaloosa for the Years Ending 30th September, 1893 and 1894* (Montgomery, Ala.: The Brown Printing Co., State Printers and Binders, 1894), 17,18. Searcy stated that because of the exertion of physical labor, the men were quieter at night than the women. Searcy also noted that he found it interesting that one of the patients had stated in reference to the patients' labor that the hospital was now an industrial hospital.

were the worse because they housed the "prostitutes and criminals, provided less physical freedom, and removed one from the hospital's main channels of life and activity."[66] Without entirely abandoning his predecessor's tenets of moral treatment, or resorting to the use of restraints, Searcy could chastise Sheffield by placing her in the backwards, using ward relocation as a tool for behavioral modification. At the 1903 National Conference of Charities and Correction, Searcy's "For What Classes Should the State Make Provision?" asserted that the reasoning for moving a patient from one ward to another, "to a better or a lower grade, serves often as an excellent remedial measure. The discipline … has a beneficial effect. The principle … is not punishment, but is a readjustment of class."[67]

According to Hughes, the administration never allowed Sheffield to travel outside the compound during her thirty years of confinement. Although her letters indicated that she occasionally obtained the right to occupy a private room, the staff still denied her permission to lock her door or to go alone to the lavatory, a room containing no stalls. In her letters, she wrote endlessly on how she yearned for a moment of liberty or privacy. She also complained of her constant submission under the authority of a nurse or an attendant, people whom she classified as inferiors. According to Hughes, the hospital records indicated that Sheffield died in 1920, suffering from a combination of illnesses: old age, influenza, and pellagra. Since her family refused her body, the hospital buried

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[66]Hughes, 23, 169. In her letter of May 28, 1908, Sheffield classifies herself as of the indigent, prostitute and criminal class of patients.

[67]James Searcy, "For What Classes Should the State Make Provision?" *Proceedings of the National Conference of Charities and Correction, 1903* (Boston: George H. Ellis, 1904), 425. *See also* J. T. Searcy, "A Manual on Mental Abnormalities," Alabama Pamphlet Collection, Alabama Department of Archives and History, Montgomery.

Sheffield, as they had hundreds of others, in a grave with a small three-leaf clover marker in the graveyard located on the hospital grounds.[68]

Superintendent James Thomas Searcy: a Friend of African-American Inmates

James T. Searcy graduated from the University of Alabama in 1859, served in the Confederate Army as a sergeant major, and graduated valedictorian of his class at the University of New York in 1867. After graduation, he practiced medicine with his father, Dr. Reuben Searcy, until Reuben's death in 1887, at which time he replaced his father as President of the Alabama Insane Hospital Board of Trustees. After Bryce's death in 1892, Searcy withdrew as President and became the asylum's new superintendent. Besides following Bryce's philosophy of moral treatment and occupational therapy, Searcy also shared Bryce's beliefs of predisposition, that the major cause of insanity was heredity, and minds that were idle deteriorated. In addition, he aspired as the new Superintendent to promote a progressive policy of rehabilitation at the asylum. However, where Bryce had harbored a special interest in the criminally insane, Searcy focused on the illnesses and the needs of the asylum's African-American patients.[69]

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[68]Hughes, 210. Sheffield died the same year as Superintendent Searcy. *See also* "Bryce Cemetery," AlGenWeb:County Index:Tuscaloosa County: Cemeteries, available from http://www.rootsweb.com/~altuscal/cemetery/bryce.html; Internet; accessed 03 November 2006. Bryce Hospital has three cemeteries. In the early years, the white patients' markers were made of wood, and the black patients were made of concrete. Over generations, many of the wood markers deteriorated, whereas the concrete markers remained in tact. On other graves, the markers were small stones about 5" x 5" with a number on them which could be cross referenced back to a patients' name, or were marked with an iron cross and a patient number. The crosses bear the initials A.I.H. for Alabama Insane Hospital. By 2006, approximately 200 crosses remain out of 1,000 graves in that part of the cemetery.

[69]Thomas McAdory Owen, *History of Alabama and Dictionary of Alabama Biography,* vol. 2 (Spartanburg, South Carolina: The Reprint Company, 1978), 1518–1519. Searcy was born on December 10, 1839 at Tuscaloosa, Alabama. Searcy was President of the Alabama Medical Association, on the state board of the American Medical Association, a member of the Medico-legal Society of New York and the American-medico Psychological Association. Searcy married Annie Ross on January 22, 1868 and the

In 1893, the re-named Alabama Bryce Insane Hospital housed over one thousand patients.[70] According to Harvey B. Searcy's *We Used What We Had,* his father, James Searcy, knew that because of the patient overload, the asylum could not accept any new admissions of African-Americans. The lack of state appropriations for additional buildings and the required "separate but equal" law of 1891 had placed the superintendent in an uncompromising situation. To compound his problems, the buildings currently used for housing the black patients were grossly inadequate. For example, the Gray-Stone, the hospital's farmhouse used for housing the black farm workers could only hold a limited number of unsupervised African-Americans, and as it was, it was extremely overcrowded. The Annex, used for housing the African-Americans who worked in the laundry was also too small and was stretched beyond comfort for those already residing there. Seeking a solution to the mandate, Searcy contacted associates employed by the federal government in Washington, D.C. and requested the use of an abandoned military fort located at Mount Vernon, two hundred miles south of Tuscaloosa, for the residency of the state's African-American patients.[71]

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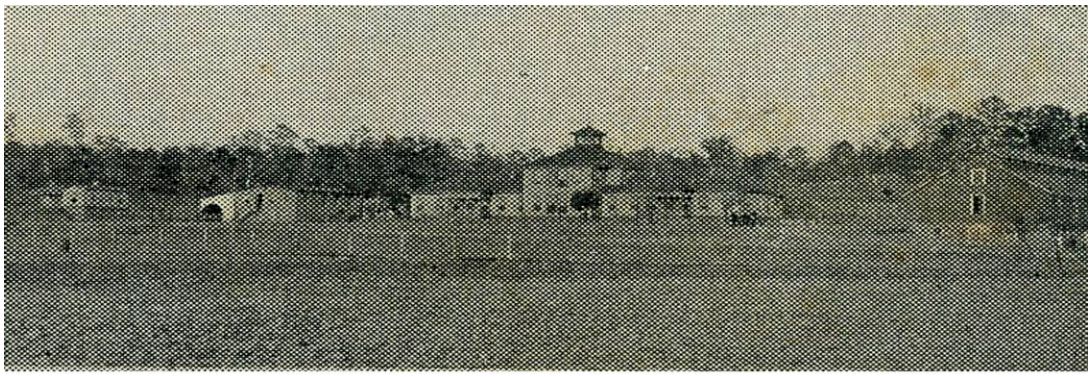
couple had twelve children, eight boys and four girls. Searcy was a Democrat and an elder in the Presbyterian Church.

[70]*Acts of 1893*, 344. On the motion of Governor Thomas G. Jones, the Board of Trustees requested the state legislature to incorporate Bryce's name in that of the hospital. On February 8, 1893, the Alabama Bryce Insane Hospital became the asylum's new name. On December 11, 1900, the state Legislature changed the name of the Alabama Bryce Insane Hospital to The Bryce Hospital.

[71]Harvey B. Searcy, *We Used What We Had* (Northport, Alabama: Colonial Press, 1962), 35. Harvey worked as a dentist at Bryce Hospital for a few years and then went into private practice in Tuscaloosa. He states that working with the asylum's geriatrics and retardates required more stamina than he had. Later, he served as a trustee on the asylum's Board.



Gray-Stone Farm

Figure 3. The *Biennial Report of the Alabama Bryce Insane Hospital, at Tuscaloosa, for the Years Ending 30th September, 1895 and 1896* (Montgomery, Ala.: Roemer Printing Company, State Printers and Binders, 1896).

On March 1, 1895, the federal government assigned the Mount Vernon fort over to the state of Alabama as long as it functioned as a facility for the care of mentally ill African-Americans. On December 11, 1900, Act 26 of the General Assembly allocated the fort to the Board of Trustees with a twenty–five thousand dollar appropriation for renovations.[72] Surrounded by sixteen hundred acres of good farmland, Searcy estimated that with some upgrading the state could have a hospital capable of servicing five hundred patients. After several months of renovations completed by the inmates from Bryce Hospital, the hospital was ready for its new residents. Harvey Searcy recalled that in May 1902, about three hundred black patients of the "highest grade mentally and physically along with twenty-five employees including one physician and one intern,

[72]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901* (Montgomery, Ala.: A. Roemer, Printer for the State of Alabama, 1901), 64–65.

were loaded on a special train … and given lemonade and cake," before arriving at the Mount Vernon Hospital.[73]

The Mount Vernon Hospital Administration Building

Figure 4. W.D. Partlow, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) To The Governor with Annual Report of the Superintendent for the Year Ending September 30, 1939.*

In 1901, Alabama's Legislature had prepared a new constitution allowing for several new adjustments to the state's responsibility in protecting and caring for the mentally ill. The 1901 Constitution clearly defined the functions of the institution, newly named The Bryce Hospital, and any future state mental health institutions. Anticipating the opening of the new asylum for African-Americans, The Mount Vernon Hospital, the state decided to place the two institutions under an umbrella department, the Alabama Insane Hospitals, which was controlled by one Board of Trustees. The Board still consisted of seven members, but now, instead of a six-year appointment renewed by the

[73]Searcy, *We Used What We Had*, 29-36. After Dr. James Searcy's retirement in 1919, the Legislature changed the hospital's name to The Searcy Hospital.

governor, their terms were extended to seven years and were self-perpetuating. The law also placed the superintendent on the Board as an executive member. The Trustees were to elect the superintendent, who was to serve for a minimum of eight years, was accountable only to the Governor and to the Board of Trustees, and was "a physician of good business habits, of a humane disposition, a graduate of medicine, and a man of good moral character."[74]

The 1901 Constitution also listed the legal requirements for admission to the asylums and the state's fiscal responsibility for the indigents. Before requesting the approval of the individual's county probate judge, the family or the person(s) committing the afflicted individual would have to complete a lengthy questionnaire at the asylum. Once the superintendent notified the judge that the asylum had a vacancy, the judge was to summon witnesses, at least one of whom was to be a physician, and investigate the accusations concerning the citizen's mental stability. However, the state gave the superintendent the final authority in admitting or in declining the patients when the "wards of the white men and women, or the wards of the colored men and women are crowded, as the case may be." [75] In other words, if the superintendent deemed the hospital overextended, he, as he had since the day the asylum had opened, had the authority to refuse any new admission.[76] As stated in the 1871 Act, the indigents were

[74]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901*, 361–362. *See also* Alabama, *Constitution Convention, 1901: Official Proceedings of the Constitutional Convention of the State of Alabama, May 21, 1901, to September 3, 1901*, vol. 2, Section 47 (Wetumpka Printing Co., Wetumpka, Ala., 1940), 2616.

[75]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901*, 363–367. The bond for paying patients decreased from $500.00 to $300.00.

[76] Searcy, "Biennial Report of the Superintendent of the Alabama Bryce Insane Hospital, for the Years 1893 and 1894," 9, 11–13. A comment of Bryce's that Searcy agreed with and often repeated in his

and remained wards of the state and not the counties. The state allocated three dollars a week for the patient's expenses and for "the support, repair, and improvement of the institutions."[77]

Finally, the 1901 Constitutional Convention addressed the 1875 Constitution decree that had specifically forbidden the acceptance of addicts and feebleminded people to the state asylum. Cognizant of the administration's lack of adherence to the law, the legislators wrote in the new constitution that the responsibility of patients whose mental derangement was "that of a fit of intoxication or delirium of acute sickness or persons who are simply and permanently weak-minded, imbecile, idiotic, or otherwise demented" belonged to the care of their local county poorhouses. The law specifically stipulated that the state asylums were to operate "solely for the care, treatment, and custody of insane patients."[78] In case the need for future clarification arose, the constitution went so far as to define insanity:

> [One] who, because of mental derangement, deficiency or defectiveness, is indecent in conduct or constantly troublesome to others; or who is a menace to the peace, welfare, or safety of others; or who is dangerous to his (or her) own life or safety; or who is destructive of property.[79]

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reports was that the major function of the hospital was that of a "dumping ground" for the indigent, the feebleminded, and the elderly from all over Alabama. Searcy deplored the large number of elderly confined to the hospitals, but he knew that if it was impossible for the hospital to locate their kin, and the county poorhouses were ill equipped to care for these people. Searcy had repeatedly recommended that the State Legislature should step forward in a social effort to improve the county care of paupers, which obviously would in turn help to decrease the number of geriatrics admitted to the mental hospital. See also Reed, 307. Hoping that a different field would provide a more profitable yield, tenant farmers had habitually left one farm for another. Consequently, the farmers never established permanent homes, and their kin were usually scattered across the state and beyond.

[77]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901*, 367, 373.

[78]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901*, 363.

[79]Alabama, *Acts of the General Assembly of Alabama, passed at the Session of 1900–1901*, 363. The 1875 Constitution had specifically forbidden the acceptance of feebleminded patients to the asylums, yet the Superintendents continue to allow their admittance.

Contagious Afflictions: Prevalent Among African-Americans

According to Searcy, he had problems at the two asylums that were more serious than the legislators' new constitution or their views on addicts and the feebleminded. At Bryce, but more so at Mount Vernon, the patients had had a continual ailment of skin rashes on their faces, arms, and legs. By the fall of 1906, there were eighty-eight cases at Mount Vernon and fifty-seven of them had died. The superintendent, searching for the cause of the rash, consulted the advice and assistance of one of his sons, Dr. George Searcy, who identified the rash as pellagra.

According to George Searcy's "An Epidemic of Acute Pellagra," pellagra was an endemic disease based on predisposing factors such as eating damaged corn, poverty, poor hygienic surroundings, and exposure to the sun's rays. Searcy asserted that the disease manifested itself by weakness and an enervated condition. Of the eighty-eight cases at Mount Vernon, eighty were females with an average age of thirty-four, all had been in the hospital longer than one year, and two-thirds of them had previously been of good health. The prognosis for the Mount Vernon cases was unfavorable, with death ensuing in most cases in two to three weeks. For those who recovered, the recovery was very slow, with the patient remaining feeble and typically depressed for months. Searcy found it interesting that none of the nurses had the disease. The chief difference in their life style was their diet, as he knew the nurses ate little corn bread and had a "variety of diet." Checking the asylum's kitchens and its supplies of corn meal, George Searcy found the meal to be moldy. After sending the meal to a laboratory of plant pathology in Washington, D.C., Searcy receive a report that stated that the meal was unfit for human

use.[80] According to Elizabeth Etheridge's *The Butterfly Caste: A Social History of Pellagra in the South,* George Searcy wrote his congressman and the Surgeon General asking for assistance in addressing the growing problem of pellagra in the South. Etheridge also states that most pellagrins had the mark of a red butterfly across their face. This mark became a "stigma which set them in a caste of the Southern poor, a social and economic condition of the early twentieth century South."[81]

Dr. E.M. Mason, Alabama's state bacteriologist and pathologist proclaimed that there were approximately three hundred cases of pellagra in Alabama. On April 1910, he addressed the Medical Association of the State of Alabama and proclaimed that the common belief of pellagra being contagious was based on the erroneous idea that any disease with skin manifestations of such severity must be directly transmitted from one person to another. Mason asserted that as the intensification of the infection progressed the afflicted would become mentally depressed, tend not to speak, and would suffer from periods of acute mania, which often manifested themselves in the form of self-destructive behavior.[82]

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[80]George H. Searcy, "An Epidemic of Acute Pellagra," (Chicago: Press of the American Medical Association, 1907), 5, 1–6. Pamphlet Collection, Alabama Department of Archives and History, Montgomery. Superintendent Searcy claimed to have purchased the best western meal available and was shocked at the D.C. report. See also Dave Parks "Unraveling pellagra's cause teaches lesson in public health," *Birmingham News* 2 October 2006, p. 1d. The disease exploded throughout the South, where people ate a corn-based diet. No one knew what caused pellagra, and so called "pellagrins" were shunned and treated like lepers, a phenomenon known as "pellagraphobia." Dr. Joseph Goldberger of the U.S. Public Health Service found that according to Alan M. Kraut's *Goldberger's War: The Life and Work of a Public Health* The disease caused by a dietary deficiency of nicotinic acid.

[81] Elizabeth Etheridge, *The Butterfly Caste: a Social History of Pellagra in the South* (Greenwood Publishing Company: Westport, Connecticut, 1972), vii–viii, 16.

[82]E. M. Mason, "Pellagra," *Journal of the Southern Medical Association* (July 1910), 2–7. Alabama Collection, Special Collections, Ralph B. Draughon Library, Auburn University, Auburn.

With nearly one-third of the state's pellagra cases diagnosed at Searcy, many white Alabamians thought the disease to be prevalent among African-Americans. Compounding the biases was the fact that the second largest cause of death at Mount Vernon was tuberculosis with a fifteen percent death rate and the third was syphilis at eight percent. Consequently, many citizens surmised that black patients were carriers of contagious diseases; a bias that allowed Alabamians to blame the African-Americans for the asylum's problems. Although the asylum's problems were many, such as the high census of patients, inadequate funding from the Legislature, and inadequate staffing, the core of the problems converged not on the patients' illnesses but on discrimination.[83]

Somewhat alarmed by the state's lack of social responsibility for its afflicted, socially minded Governor Charles Henderson, who was elected in 1915, requested an inquiry from the Russell Sage Foundation concerning, among other social issues, its evaluation on the conditions of the state's two asylums, such as its "provisions for feeble-

[83]Elizabeth Wisner, *Social Welfare in the South: From Colonial Times to World War I* (Baton Rouge: Louisiana State University Press, 1970), 110–112. According to Wisner, there were many conflicting perspectives on the theory of insanity among African-Americans during the Progressive Era. Wisner refers to Dr. Mary O'Malley's "Psychoses in the Colored Race" which estimated that while the black population from 1860 to 1910 had increased by one-hundred-and-eleven percent, insanity among the blacks had increased by one-thousand-six-hundred-and-seventy percent. Clinical director of the Georgia State Sanitarium at Milledgeville, Dr. E. M. Green claimed the hypothesis that the cause of insanity among African-Americans was due to a lack of proper nutrition, beginning as pellagra and ending as insanity. On the other hand, in an address before the National Conference of Charities and Corrections in 1908, Dr. William F. Drewry, superintendent of the Virginia State Hospital for the Insane, an institution exclusively for African-Americans, argued that emancipation had triggered mental instability; freedom had left the African-Americans unprepared for making decisions or for controlling their passions. William D. Partlow, "Degeneracy," Alabama Pamphlet Collection, Alabama Department of Archives and History, Montgomery. However, according to Searcy and Assistant-Superintendent Dr. William D. Partlow, insanity among the African-Americans was anthropological. Partlow's "Degeneracy," a paper delivered to the Alabama State Medical Association in 1907, affirmed the importance of "an inborn weakness or predisposition" and that the inmates were "insane as a result of the misdeeds, sins, or errors of their ancestors," in other words, according to Partlow, "a reversed Darwinism." See also W. D. Partlow, "Hereditary Tendency," delivered to the State Medical Association in 1909. Partlow affirms the importance of "predisposition as a causative factor of disease. A proper understanding and observance of the laws of heredity would ultimately result in racial improvement," but if disregarded, it would "ensued individual, lineal, and racial decline."

minded children, epileptics, and delinquent negro girls … [and] separate wards for the cases of tuberculosis and pellagra."[84] After reviewing the Superintendent's 1910–1914 annual reports and observing the two asylums for a few weeks, Hastings H. Hart filed his report. The reports listed the two hospitals with a population of fourteen hundred white patients and eight hundred black patients and a weekly appropriation of three dollars, one dollar less then what it had been fifty years earlier.[85] Hart's "Social Problems of Alabama" stated that both hospitals received equal allocations of money from Superintendent Searcy. His report also indicated that the female supervisors made five dollars a month more than the male supervisors did. However, he did note the discrepancy between Searcy and Bryce Hospitals in that Bryce had a three-year training school for nurses and a full-time dentist. In conclusion, he wrote that both hospitals "equipment is painfully inadequate … no suitable laboratories, hydro-therapeutic treatment … [or] separate provision for tuberculous patients."[86]

As the price of cotton increased dramatically during World War I, Alabama encountered a substantial increase in state revenue. With this surplus, Governor Henderson increased the weekly per capita from three dollars to three dollars and fifty cents. Noting this period of fiscal improvement at the institutions, eighty-year-old Superintendent Searcy decided to resign. In 1920, one year after retiring, Searcy died,

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[84]Hastings H. Hart, "Social Problems of Alabama: a Study of the Social Institutions and Agencies of the State of Alabama as Related to its War Activities," (New York: Russell Sage Foundation, 1918), 5, 10. Henderson states that it would be suicidal for the legislators to vote for an increase of taxation.

[85]James Searcy, "Superintendent's Report to the Board of Trustees at their Annual Meeting, October 21st, 1914," *Report of the Trustees of The Alabama Insane Hospitals, To The Governor, for four years, ending September 30th, 1914* (Hospital Printer), 9, 11.

[86]Hastings H. Hart, "Social Problems of Alabama: a Study of the Social Institutions and Agencies of the State of Alabama as Related to its War Activities," 12.

and in 1922, in recognition of his service to the hospitals and particularly for his perceived devotion to the African-American patients at Mount Vernon, the Legislature renamed The Mount Vernon Hospital to Searcy Hospital.[87]

By 1922, Governor Thomas E. Kilby, who also supported the improvement of public health services, voiced his concerned over the growing census at the asylums as well and requested a follow-up report to the previous Sage study. Hart's "Social Progress of Alabama" reported that the past general standards of medical treatment and nursing care continued to prevail at both mental health hospitals. He stated that under the new Superintendent William Partlow's supervision, the female supervisors' monthly salaries had increased from fifty dollars to one hundred and twenty-five dollars and the male supervisors' monthly salary had increased from fifty dollars to one hundred and fifteen dollars. However, Hart noted that although there had been a supplementary appropriation provided from the state to improve the conditions of the patients' wards, construction had not begun on the wards, but did notice that the administrative building had been renovated. He also commented on how the expenditure for food, fuel, and clothing at Bryce Hospital had not increased with the new appropriations. In reference to Searcy Hospital, Hart claimed the nurses received the same pay as the nurses employed at Bryce Hospital, and the assistants received a salary of twenty to thirty-five dollars per month, plus board. According to Hart, the twenty-one white nurses with nineteen male African-American assistants at Searcy exercised the same skill and gave the same conscientious care to its patients as was practiced at Bryce. Hart concluded by proclaiming how Alabama's progress in treating its mentally ill was the result of the combined efforts of

[87]Vickery, 92. Searcy died on April 6, 1920.

"the Governor, the Legislature … the clergy, and the men and women of the great State of Alabama."[88]

Conclusion

As the mental health administration expanded to include The Mount Vernon Hospital, Superintendents Peter Bryce and James Searcy worked to develop and to continue the philosophy of moral treatment and occupational therapy. Yet, were their motives sincere? Was it out of necessity that the asylums had become and had remained self-supporting plantations worked by unpaid indigents? For generations, the Alabama Legislature had added to the social disregard for farmers by its continuation of implementing policies that had created a class of both white and black indigents. They were people who had become ill because of inadequate food, housing, and education. They were also human beings who had been involuntarily committed to state mental health institutions because of their ensuing illnesses. They were citizens who also suffered from unwarranted political liabilities imposed by the Legislature's denial of their constitutional right to vote and its projection of an unfair image of backwardness and ignorance of the farmers and the mentally ill patients. Finally, once committed, the state with its laissez-faire attitude continued its failure to safeguard the indigents' rights to receive minimum medical treatment for their improvement.

[88]Hastings H. Hart, "Social Progress of Alabama: a Second Study of the Social Institutions and Agencies of the State of Alabama" (Montgomery, Alabama: Bewon Pinting Co., 1922), 6, 2, 6–13.

CHAPTER III. LEGAL ISSUES IMPACT THE RIGHT FOR MORAL TREATMENT

Introduction

Both the 1875 and the 1901 Constitutions established the guidelines for admissions, the duration of commitment, and release procedures for Alabama citizens involuntarily committed to Alabama mental health institutions. Those guidelines seemed to cement the place of the mentally insane as eternal wards of the state. The constitutional frameworks also introduced degrading stratifications for Alabamians accused of mental illness or mental retardation. As the population in Alabama grew, so did the population in the hospitals. Stigmatized and shunned as social misfits, these patients were typically committed through a legal procedure requested by their families. The process consisted of a hearing conducted by the local probate judge, normally conducted in as few as two minutes, and once committed, unless requested by a family member for their discharge, the institution rarely released the patients, who were now in effect inmates. Despite the glaring shortcomings to its approach, the state continued to take pride in its meager appropriations for social services that made insufficient provision for treatment of the mentally ill and for sufficient salaries to staff asylums adequately. Over time, these led to the hospital's administrative policy of apathy in its custodial care of residential patients. Up until World War II, the legal system deemed the abusive policies towards

involuntarily committed people with mental disabilities by state mental health institutions as acceptable.

Nevertheless, something had changed in Alabama. After the devastation of World War II, the awareness of soldiers suffering from combat mental disorders was on the rise. Furthermore, as the spiritual needs of humanity became a forerunner of public concern, the social awareness of the spiritual needs of the mentally ill and their right to pray and seek faith began to grow. The returning veterans and organizations such as the NAACP also began to challenge past legal acceptances of racial discrimination and neglect. Hence, Alabama legislators began to hear from concerned constituents in reference to the patriotic and spiritual needs of those who had offered their lives to protect Alabamians' constitutional rights were involuntarily committed to the mental hospitals. Thus, civic and health organizations also began to voice concerned over the functions and practices of the state mental hospitals. Reform began to appear in 1951, with the formation of the Division of Mental Hygiene under the direction of the State Department of Public Health. Yet, still unsatisfied with the direction of medical services for the mentally ill and retarded, concerned citizens rallied and received in 1965, a Department of Mental Health.

One may ask whether the indigent men and women of both races who had been involuntary committed to the state mental health institutions were not also legally protected under the United States Constitution, with its guarantees of liberty and due process of law. Ronald Dworkin's *Taking Rights Seriously* discusses the impact of the judicial system on society, such as the two Supreme Court rulings: *Plessey v. Ferguson* which condoned "separate but equal" in 1896 and *Buck v. Bell* which condoned the doctrine of involuntary sterilization of the feebleminded. A professor of law and

philosophy at New York University, Dworkin argues that due to the broad overview of the law, most judges ruled in favor of the majority's good instead of the individual. By doing so, Dworkin reasons that judges had historically played it safe by not becoming involved with "the moral aspects of the law or the moral issues of an individual's right to dignity and political equality."[89] Yet, he proclaims that if a government is to take constitutional rights seriously, it must give priority to the individual over the masses. Concerning gray areas, Dworkin maintains that judges should decide what a person's rights are and using a process of moral ruling should rule in favor of those rights.

However, he asserts some of the past confusion of judicial rulings lies in the ambiguous definition of "a right." One can view it as "having a right," as "the right to do," or at times, as a weaker definition, "is it right."[90] Nevertheless, according to Dworkin, whatever view dominates, "the government must treat those whom it governs with concern, that is, as human beings who are capable of suffering with respect," and that people have "fundamental legal rights that pre-exist legislation."[91] Overall, Dworkin states that acknowledgement of concern and respect is essential if a person's basic right of due process is to be taken seriously. For many in the South and especial for those in institutions for mental disabilities, they find it impossible to maintain a sense of dignity in an environment that legally deprives them of their constitutional rights.

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[89]Ronald Dworkin, *Taking Rights Seriously* (Cambridge, Mass.: Harvard University Press, 1977), 272–273.

[90]Dworkin, 274.

[91]Dworkin, 274.

“The Feebleminded”: “Idiots, Imbeciles, and Morons”

The legislators who crafted Alabama’s state constitution in 1875 wrote that “idiots, imbeciles, and morons” were the responsibility of their respective counties and were not to be admitted to the state-supported asylum if that would interfere with the admission of those who were insane. The hope that the denial of the feebleminded would reduce the population at the asylum had not been borne out, and in the subsequent 1901 Constitution the policy was reasserted. While acknowledging the qualifications that the constitutions outlined and understanding their implications for those less able to survive, Superintendent James Searcy had chosen to ignore the constitutional provisions and during his tenure continued to admit a small number of those classified as idiots, imbeciles, and morons to both hospitals. According to Searcy, the hospitals’ difficulties did not stem from the type of patients it contained, but from the lack of state funding.

Another legal issue Searcy had avoided while serving as superintendent was eugenics. Although Searcy had affirmed the benefits of eugenics, he thought society would never view many eugenic practices as acceptable. Assistant-Superintendent William Partlow had strongly disagreed. Sharing the prevailing views of the heritability of mental conditions, and abiding by the Progressive Era’s theory of efficiency and rationalization, Partlow believed that in order to prevent the propagation of mental deficiency through reproduction, all defective individuals should be committed to institutions rigorously segregated by race and gender. Concerned by his perceptions of an increase in the population of mentally disabled citizens and their dependency upon state welfare, Partlow also insisted upon their involuntary sterilization. It was because of these

convictions that Partlow worked so relentlessly to establish The Alabama Home for Mental Inferiors and to promote laws legalizing eugenics.[92]

According to Vickery, the Committee for the Protection of Feebleminded Children's report to the State Medical Association on April 20, 1915, estimated that one out of every three hundred Alabamians was feebleminded. According to Dr. W.F. Drewry, superintendent of the Central State Hospital in Virginia, the national average was one out of every five hundred.[93] Concerned by these statistics, Tuscumbia's state Representative A. H. Carmichael introduced a bill on January 28, 1915, to establish a home for the those seen as "defectives." However, due to insufficient state funds, the bill never came to a vote. Not discouraged by this setback, Partlow diligently called upon a number of prominent citizens representing the Medical Association of Alabama, the Alabama Society for Mental Hygiene, the Alabama Education Association, and the Alabama Federation of Women's Clubs and urged them to keep the goal of institutionalization at the forefront of their agendas. [94]

After two years of promoting the need for institutionalization, Partlow was successful in achieving his goal. On January 23, 1919, Jefferson County Representative George Ross introduced bill H166 in the Alabama legislature. The proposed legislation sought to define "mental inferiors," stated provisions for their care, treatment, and training, and requested funds from the State Treasury for the establishment and

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[92]Vickery, 152-154. President of the Human Betterment Foundation in Pasadena, California, Dr. E.S. Gosney's *Sterilization for Human Betterment*, advocated sterilization as the "cure" for the problem of feeblemindedness. According to Vickery, it was a hypothesis conveniently accepted by the public as a solution for many of its social ills, including criminal behavior, poverty, and insanity.

[93]William F. Drewry, "Care and Treatment of the Defectives in the South," *History of the Social Life of the South*, vol. X (Richmond, Va.: L.H. Jenkins, 1909), 597–602.

[94]Vickery, 152–154.

maintenance of a Home for their care. Union Springs Senator S. C. Cowan introduced the bill as §309 in July, and Governor Charles Henderson signed the bill for The Alabama Home for Mental Inferiors into law on September 29, 1919.[95] Partlow's quest for an institution for the feebleminded threatened to run aground due to the Legislature's concerns over the state's financial standing. The state anticipated a recession in the aftermath of World War I and the accompanying devaluation of cotton as a commodity. Their fears were well-founded, and the ensuing economic recession resulted in the delay of the opening of the institution until August 1923.

Alabama Home for Mental Defectives

Figure 5. W.D. Partlow, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) To The Governor with Annual Report of the Superintendent for the Year Ending September 30, 1939.*

In 1923, under the leadership of Governor William W. Brandon, the Legislature amended its 1919 laws that had established The Alabama Home for Mental Inferiors. The new Acts re-named the institution as The Alabama Home for Mental Defectives, defined

[95]Alabama, General Laws (and joint resolutions) of the Legislature of Alabama (Montgomery, Alabama: The Brown Printing Company, 1919), 1026. Act 704, Section 10.

the term "mental inferiors," established the controlling body of the institution, provided the terms for the care and treatment of the individuals, and appropriated the funds from the State Treasury. Act 568 of the general laws defined the feebleminded as idiots, imbeciles, morons, and any epileptic. It also stated that the Board of Trustees of the Alabama Insane Hospitals, the Governor who was an ex-officio member of the Board, and three other persons, two of whom were to be females and appointed by the Board, were to manage and control the Home. The superintendent was to appoint an assistant-superintendent who would be in charge of the Home. Section 13 empowered the assistant-superintendent and the superintendent the authority to sterilize any inmate and to deny an inmate parole or dismissal from the institution. The state required that the inmates be placed according to "age, sex, color and grade of deficiency," directed that they be "employed and trained in farming, gardening, and mechanics," and stipulated that the institution must afford "schools, church worship, amusement, and diversion conducive to the health, happiness and moral and mental improvement of the inmates."[96] Act 17 provided from the state treasury's general funds the Board an allocation of seven dollars and fifty cents per week for the first year for each inmate and an allocation of five dollars thereafter.[97] Four years later, the United States Supreme Court *Buck v. Bell* ruling, approved of the sterilization of the feebleminded. The opinion of the court stated that Buck, an eighteen year-old female who had been sterilized in 1924, had not been denied due process of law. That same year, Alabama's Legislature, in response to Partlow's

[96]Alabama, *General Laws of the Legislature of Alabama passed at the Session of 1923*, (Montgomery, Ala.: Brown Printing Company, 1923), 743.

[97]Alabama, *General Laws of the Legislature of Alabama passed at the Session of 1923*, 11–13, 738–745.

dedication to the eradication of the feebleminded from society, changed the name of The Home to The Partlow State School for Mental Defectives.

Dr. William Dempsey Partlow: Eugenics as a Means of Cleansing Alabama's Society of Mental Retardation

William D. Partlow was born in Ashville, Alabama, on February 4, 1877. After graduating as valedictorian from the Mobile Medical College of Alabama in 1901, Partlow worked as a physician at The Bryce Hospital until October 1908, at which time he became assistant-superintendent. In 1917, he served as president of the State Medical Association of Alabama.[98] In 1919, Superintendent Searcy nominated Partlow to the Board as his replacement for the position of superintendent of the Alabama Insane Hospitals. Like his predecessors, Superintendent Partlow advocated both moral treatment and occupational therapy and strived to maintain "through the example and harmonious efforts of all officers, nurses, attendants and other employees, an atmosphere pleasing, comforting and homelike."[99]

In 1926, Partlow's annual report indicated that the hospital had treated forty-five hundred patients that included approximately eleven hundred new admissions with nine hundred of whom were released. The report listed Bryce professional employees as one

[98]Owen, *History of Alabama and Dictionary of Alabama Biography*, 1324. Partlow was a member of the American Medical Association and the American Medico-psychological Association. He was a Methodist. In 1905, he married Margaret Cummings and they had three children. Because of emphysema and his debilitating health, Dr. James Tarwater had function as Superintendent. Partlow retired in 1950, a time when society and public health services were changing for new concepts in the treatment of the mentally ill.

[99]William Partlow, "Superintendent's Report, Bryce Hospital, Tuscaloosa, Alabama, November 10, 1926," *Report of the Alabama Insane Hospitals to the Governor with Annual Report of the Superintendent for the Year ending September 30, 1926* (hereafter *Annual Reports*), 13.

assistant-superintendent, five physicians, one interne, and one dentist, and the Searcy employees as one assistant-superintendent and two physicians. As the two hospitals' residential census grew to approximately two thousand white patients and one thousand black patients, Partlow's annual reports repeatedly referred to the institutions established policy of non-restraint and farm labor. In his quadrennial report to the Board of Trustees that covered years, 1923–1926, he wrote of the services provided by the two institutions, "the modern plan of regarding the inmates as patients in a hospital for scientific medical examination and treatment … their complaints, requests and appeals patiently heard and often yielded … with more privileges, occupations … giving them the chance to return to normal."[100] Partlow referred to the credit of Drs. Peter Bryce and James Searcy administrations in providing the application of progressive remedies of moral treatment and occupational therapy. Partlow also stated his plans to carry the occupational therapy application to a more organized systematic plan in which a larger percent of the patients would work. Perhaps aware of the importance of appearances, Partlow reiterated that the therapy was voluntary, with "the patients being induced and encouraged but never compelled to work."[101]

While acknowledging in the report the state's appropriations of eight hundred thousand dollars during the past four years, Partlow dutifully praised the patients and how they, through their labor, had contributed to the hospitals growth. Partlow also expounded on the augmentation of the hospitals' net worth through his efforts of purchasing adjacent lands and building substantial additions to the hospital facilities, all without

[100]Partlow, *Annual Reports, 1926, 8–9.*

[101]Partlow, *Annual Reports, 1926*, 12.

supplementary appropriations. According to Partlow's tables, the farms' gardens, dairies, and orchards had a wholesale value of approximately three hundred thousand dollars. In conclusion, Partlow listed the total value of the two institutions at approximately two-and-half million dollars.[102]

In the past, each governor had reacted to the needs of the institutions differently; some were more helpful than others were. One who was helpful was Governor Bibb Graves. According to William Gilbert's "Bibb Graves as a Progressive, 1927-1930," due to public demands for more social services, Governor Bibb Graves' administration had abandoned the old Jeffersonian ideal of "hands-off" government. Gilbert states that Graves' administration expanded socioeconomic legislation by increasing the state's tax revenue by fifty-eight percent, appropriating additional funds for the mental health institutions, and increasing the weekly per capita appropriations for the patients to four-dollars-and-twenty-five cents. His administration also awarded the Board of Trustees three thousand acres of adjacent farmland at Bryce and funds to construct a two-hundred-bed dormitory, Treatment Center Number Two, that would assist in accommodating the four hundred African-American patients housed at the Colony, previously known as the Gray-Stone. For Searcy Hospital, the Board received funds to build a two-hundred-and-twenty-five bed dormitory. The Legislature appropriated to The Home approximately one hundred thousand dollars and a four dollar weekly per capita for its inhabitants.[103]

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[102]Partlow, *Annual Reports, 1926*, 8–15.

[103]William E. Gilbert, "Bibb Graves as a Progressive, 1927–1930," complied by Sarah Woolfolk Wiggins, *From Civil War to Civil Rights: Alabama 1860–1960* (University: University of Alabama Press, 1987), 340–341. *See also* Alabama, *Acts 1931*, 9.

Unfortunately the Great Depression brought serious financial difficulties to the state government, problems that cascaded down to the mental institutions. On December 1, 1932, Governor Benjamin Miller reduced the institutions' per capita allocations to three dollars, a dollar less than it was at the onset of the Civil War, seventy-two years earlier. Making matters even more forlorn, as the destitution of the Depression grew, the number of applications for admission to the hospitals also grew.[104] Partlow listed the State School as having two hundred and fifty-nine male inhabitants and two hundred and fourteen female inhabitants, totaling four hundred and seventy-three people. The state supported all but eight inmates. According to the superintendent's report, out of the total, one hundred and sixty-six were either too ill or too young to be assigned a task, otherwise, every child worked[105]

[104]Vickery, 165–167. The recommendations to the governor and Legislature for buildings at the hospitals in 1930 included at Searcy a new building to be constructed that would house 100 patients. The Legislature failed to make special appropriations, but an automatic sprinkler system was installed in all buildings at Searcy.

[105]William Partlow, "Superintendent's Report, Bryce Hospital, Tuscaloosa, Alabama, November 10, 1926," *Report of the Alabama Insane Hospitals to the Governor with Annual Report of the Superintendent for the Year ending September 30, 1926* (Hospital Printer), 99–110.

TABLE VII

The number employed each day at Partlow

	Male	**Female**	**Total**
Ward Work	24	48	72
Laundry		18	18
Kitchen and Dining Room	9	23	32
Sewing Room		9	9
Patching		10	10
School Building		9	9
Nurses Dormitory		2	2
Assisting Night Nurses	1	1	2
Doctors Residence		1	1
Vegetables		7	7
Truck	1		1
Boiler Room	2		2
Barn	4		4
Farm, Dairy and Garden	98		98
Colony	40		40
TOTAL	179	128	307

Source: W.D. Partlow, "Superintendent's Report," *Report of the Trustees of the Alabama Insane Hospitals to the Governor with Annual Report of the Superintendent for the Year Ending September 30, 1929* (Hospital Printer), 104.

Although responsible for overseeing the operation and growth of the three hospitals, Partlow's interest remained focused on mental retardation. He argued adamantly that the state should dictate the issue and should insist upon sterilizing the unfit. According to Vickery, Partlow wrote to E.S. Gosney on February 28, 1931, and informed him that in Alabama, the 1919 laws permitted him to sterilize all

institutionalized feebleminded inmates prior to their release. Gosney, a philanthropist who had formed the Human Betterment Foundation in Pasadena, California, in 1928, promoted eugenic sterilization. Partlow claimed in his letter to have sterilized forty-seven males and twenty-five females. Four years later, on January 10, 1935, he wrote Gosney again, and informed him that he had sterilized an additional seventy-seven boys and sixty-one girls; making a total of one hundred and twenty-four boys and eighty-six girls.[106] That year, Partlow asked Senator Hayse Tucker to introduce and sponsor his bill that advocated legalized sterilization for additional classifications of mentally deficient individuals.[107] The House and the Senate both passed the bill, but it was subsequently vetoed by Governor Bibb Graves. On September 5, 1935, *The New York Times* noted Graves' justification of his veto:

> We know that the enforcement of the provisions of this bill as to girls and young women will entail major operations upon many thousands. We know that an operation within the abdomen is one of the most serious of all major operations and that of necessity there will be a great number of deaths. Those who will die are innocent and pure, have committed no offense against God or Man, save in the opinion of experts they should never have been born.[108]

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[106]Vickery, 152–155.

[107]Alabama, *Journal of the Senate of the State of Alabama Regular Session, 1935* (Birmingham, Ala.: Birmingham Printing Company, 1935), 69. Tucker submitted Bill S26 on January 15, 1935. See also reference to bill H 745, p. 1421; Vickery, 155–156. Partlow defined them as "any person constantly or habitually dependent on public relief or support by charity in which such dependency may be due to mental deficiency; criminals who, in the opinion of the chief medical officer of the Convict Department demonstrated behavior that was sadistic, homosexual, masochistic, sodomistic or in any way an act of sexual, perversion, or persons who had been committed to a state penitentiary three times or more; or any charge of a reform school, industrial school, training school, or reformatory whom the person in charge had reason to suspect delinquent or dependent because of constitutional mental or moral deficiency or degeneracy which may be transmitted to offspring; and also persons who were constitutional psychopathic personalities."

[108] "Kills Sterilizing Bill; Alabama Governor Denounces Measure in His Message," *The New York Times*, 5 September 1935, p. 17. Available from ProQuest Historical Newspapers, The New York Times (1851–2004), Internet, accessed 27 June 2008.

Not to be deterred, Partlow continued his crusade to have his bill made into law. According to Edward J. Larson's *Sex, Race, and Science: Eugenics in the Deep South,* Partlow, assisted by Senator J. Bruce Henderson, Christian ministers, ladies' organizations, physicians, and biology professors from state universities, sought to enact his bill again in 1944, a decade after Graves' veto. Challenged by the Catholic Church and citizens who opposed any practice, such as eugenics, that was associated with Nazi Germany, the House killed the bill. Larson states that Partlow's "efforts to generate interest in the 1947 legislative session failed when the Alabama Federation of Women's Clubs dropped the drive."[109] With other organizations also leaving the cause, Partlow abandoned his efforts on behalf of the sterilization bill.

One of the inmates who escaped Partlow's policy of sterilization, but not the institution was Della Raye Rogers. Gary Penley's *Della Raye: A Girl Who Grew Up in Hell and Emerged Whole* adds an important element to the thesis's argument of the lack of moral treatment given to the helpless who were institutionalized. Although Gary Penley wrote the book, the pages consist of seventy-five year old Della Raye's words as she vividly recalls her twenty years at the Home, the Partlow State School for Mental Defectives. Adding credence to her story of abuse is the fact that Della Raye was not mentally retarded. She had the ability to understand what was happening to her and the mental capacity to recall events beginning from her entry into the hospital during the Great Depression to her post World War II departure in 1949. Her insight and recollection of her experiences enlightens one as to the hospital's administrative policies

[109]Edward J. Larson. *Sex, Race, and Science: Eugenics in the Deep South* (Baltimore: The Johns Hopkins University Press, 1995), 152, 106, 146–153.

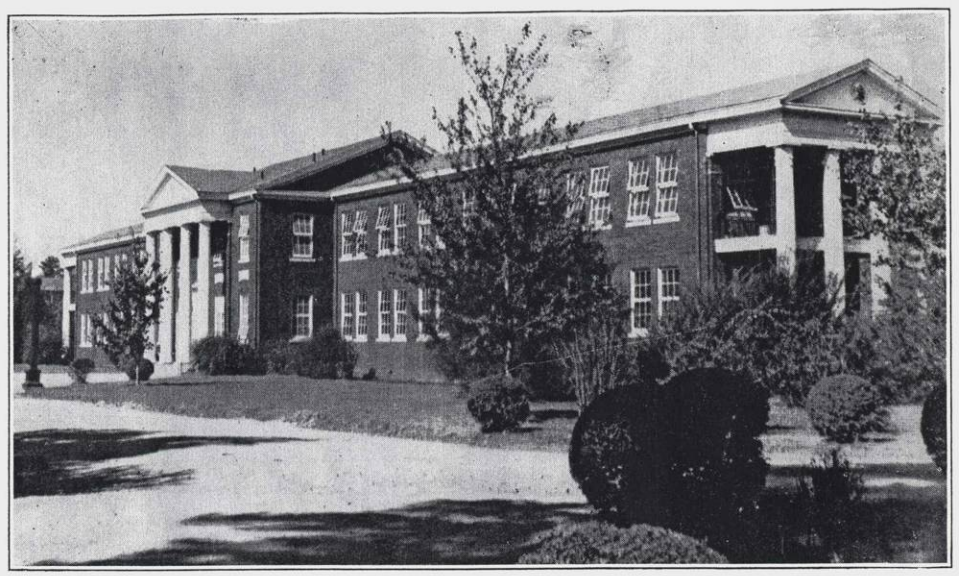
on moral treatment and occupational therapy, the negligence and brutality of the staff, and the legal power of the institution invested by the Legislature over the patient's civil rights. Furthermore, the data in Partlow's annual reports validated much of Della Raye's testimony.

Living in Athens, Alabama, sharecropper Richard Rogers could barely feed his wife much less his two simple-minded siblings and their children. Subsequently, Rogers had Dovie, Ruby, and Ruby's four year old daughter, Della Raye committed to the Alabama Home for Mental Defectives on April 24, 1929. Once admitted, the institution separated Della Raye from her mother. According to Della Raye, once inside the institution, a child was isolated from its mother and remained so until adolescence. At that time, the inmates were reunited, but only if the child was a female. Since all patients were strictly segregated by gender, a mother could neither touch nor talk to her son at any time during their incarceration.[110]

Della Raye described the Home as consisting of five buildings: the Main residence, the kitchen and main dining room, the laundry, the girl's three-story dormitory which housed one-hundred-and-sixty inmates, and the Untidy Ward. Della Raye noted that the "morons" and many "imbeciles," classified as "high grades," inhabited the large barracks-style dormitory because they were ambulatory and with proper instruction could learn to dress and feed themselves. Whereas the "idiots" or "low grades" lived in the

[110]Gary Penley, *Della Raye: A Girl Who Grew Up in Hell and Emerged Whole* (Gretna, Louisiana: Pelican Publishing Co., 2002), 7–25. Ruby also had two sons, Frank and Dickie, Jr.; Frank, who was ten years old, lived in the county almshouse, and Dickie, Jr., who was two years old, remained with Rogers. Eventually, both were admitted to the Home.

Untidy Ward where many spent their days sitting on benches or strapped to fouled beds.[111]



Dormitory for High Grade Girls

Figure 6. W.D. Partlow, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) To The Governor with Annual Report of the Superintendent for the Year Ending September 30, 1939.*

She explained that although Superintendent Partlow was the administrator of the Home, his office was in Bryce Hospital; consequently, he visited the Home on a weekly basis. The hospital's only physician, Assistant-Superintendent Dr. L.H. Woodruff, assisted by a few supervisors, nurses, and aides operated the facility on a day-to-day basis. Della Raye claimed that during her years at Partlow, she interacted mostly with the aides who the hospital permitted the patients to address as "Miss" or "Mama" but never by their first name, and in return, the staff referred to the patients, both adults and children, as boys and girls. She described the aides as unmarried females who were of

[111]Penley, 23–25.

poor backgrounds, had little if any education or medical training, and worked mostly without supervision. Their workday consisted of twelve to fourteen hours, and they received between twenty to thirty dollars a month for pay. The attendants ate their meals along with the patients in the main dining room and slept several to a room in small apartments on the top floors of the wards. The hospital granted them permission to leave the grounds on designated days, with a strict curfew regulating their return.[112]

Perpetually operating with a skeleton staff, the administration required all patients to work full time with every minute, orchestrated to a strict routine. Since the idiots and the low-level imbeciles were incapable of working, Della Raye declared that both the male and female high-grade inmates made premium stock. Most of the male patients lived and worked several miles from the institution on the Boys Colony, a two thousand acre farm. The Colony provided the meat and vegetables for the staff and the patients' consumption. Designated patients, under the stern supervision of the kitchen employees, had to prepare, cook, and serve the food to the other patients and staff. Della Raye recalled that the few paying patients ate the same food as the employees, "their food was better, more plentiful, and they could drink milk," whereas, she and the other indigents had to "drink water."[113] Another laborsaving measure used by the staff was babysitting, where the more mentally able patients looked after the less capable patients. According to Della Raye, the babysitters, fiercely loyal to the attendants who had appointed them as workers, demonstrated their appreciation for their higher status by treating their fellow patients cruelly, a behavior regarded favorably by the staff. Like the attendants, the

[112]Penley, 28. Woodruff died in 1944, and Partlow replaced him with his brother, Rufus Partlow who had been a physician at Bryce since 1912.

[113]Penley, 52.

babysitters could administer whatever punishment they fancied, with no fear of repercussions from the administration.[114]

Della Raye proclaimed that her age and, at times, her punishment dictated her assigned jobs. Initially, at four years old, she either had to clean the wards' toilets or shell peas in the kitchen; at the age of eight, she assisted in the sewing room, the laundry, and the untidy ward; at eleven, she worked in the fields, chopping and picking cotton; as a teenager, she cut the patients' hair in the hospital's beauty saloon; and by her late teens, she worked as a servant in the homes of the hospital's personnel, including the assistant-superintendent's home. Della Raye also asserted that her beatings and assigned punishment began the day she entered the institution. The beatings consisted of hair pulling, face slapping, and whippings on her back and bottom. For minor acts of rebellion, the staff either assigned her to clean the beds in the Untidy Ward or chop cotton. For defiance of staff orders, she described acts of extreme sexual and physical abuse. Commonly, in order to frighten the on-lookers as well as to humiliate and degrade the victims, the attendants would perform the abusive acts in front of the other inmates. In addition, when Della Raye ran away but was later caught, Dr. Woodruff shaved her head, administered her a douche, and then placed her in the cross-halls, an area containing antiquated cells furnished with thin straw-filled pallets and open slop jars. The hospital, according to Della Raye, used the cells for several purposes, including solitary confinement and punishment.[115]

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[114]Penley, 36–52.

[115]Penley, 57–63.

Della Raye professed that two things helped her through her twenty years at the institution: her sense of humor and her religious beliefs. According to Della Raye, Superintendent Partlow sought to create a secular environment at the Home despite some of the trappings of organized religion such as church services. He did not retain a minister and forbade visiting church groups from preaching or reading the scriptures to the inhabitants; consequently, church services consisted mostly of singing. However, at the age of five, she learned of Jesus and his love for all little children, good or bad, through another inmate, twelve year old Lula Clemons. Conscious of when and where they could discuss their spiritual feelings, the children carefully selected secluded areas to meet with other inmates, places where they could quietly express their faith. Subsequently, during the evenings, the children would diligently watch for the attendant who carried the large key ring. Who carried the key ring was a paramount issue because the keys controlled everything: the cells, the doors, even the light switches. At bedtime, the designated aide would turn out the lights and lock the bathroom doors, a method of control, according to Della Raye, used by the attendants to discourage the children from claiming they needed to go to the bathroom. After two hours of anticipation, an attendant would finally arrive, unlock the door, and then leave. In the dark, the children would sneak into the bathroom, and there, they would talk about Jesus and his love for them.[116]

According to Penley, the hospital's records indicated that Superintendent Partlow followed the methods of Dr. H. H. Goddard, a leading psychologist and Director of Research at the Vineland Training School for Feebleminded Girls and Boys in New Jersey, to rate the IQ ranges and levels of feeblemindedness of the patients. The levels

[116]Penley, 59-60.

consisted of “idiot,” less than twenty-five; “imbecile,” twenty-five to fifty-five; and “moron,” fifty-five to seventy-five. Woodruff administered Della Raye’s first IQ test on May 17, 1932, three years after her arrival at the institution. The test classified her mental IQ as sixty-seven, a six-year-and-ten-month-old child. Since the hospital had her listed as a ten-year-and-six-month old, she received the classification of “moron.” Yet, Della Raye’s real age was seven-and-a-half. This discrepancy stemmed from the fact that the institution had incorrectly classified her as seven years old at the time of her admission. However, Della Raye had been only four when admitted, consequently, they calculated her I.Q. score incorrectly.[117] After being tested, Della Raye and the “morons” who were considered capable of learning went to school for one to two hours each day. According to Della Raye, no patient over eighteen could attend, and the fifth grade was the highest level offered. Although the curriculum consisted of basic reading, writing, and arithmetic, Della Raye asserted that the merits of punctuality and the obedience to authority and teamwork took precedence over the traditional disciplines.[118]

Della Raye had always thought her Uncle had made the provision for her and her family’s admission to the institution, but she came to learn in 1942 that her assumption had been wrong. Few citizens realized that for decades, Alabama’s county doctors, medical aides, and welfare workers had made life decisions concerning the care and

[117]Penley, 29–31.

[118]Penley, 29–43, 62–65. Parallel to Della Raye’s situation was the results of tests of the African-American children, because there was serious indecisiveness as to the ages of the African-American patients. Unfortunately, undermining the dubious birth dates was the concerned over the “uncertainty of the applicability of Bine-Simon standards to the mind of the Negro child.” In 1946, a new dormitory for two hundred African-American deficients, built largely with the labor of white boys on campus, was ready for occupancy. However, it was not filled as quickly as had been anticipated and on October 21, 1948, there was room for twenty-three boys and fifty-seven girls. According to reports, African-Americans were less prone to abandon their children to institutions.

treatment of the mentally challenged. Frances Woodruff, Director of Public Welfare in Athens, was the person responsible for Della Raye being committed with her mother. According to Penley, Woodruff had not forgotten Della Raye and had formally requested her release on two occasions, one in 1942, and the other in 1944, but each time to no avail. According to Penley, after Partlow's defeat of the sterilization bill in 1935 and 1936, Partlow had tightened the Partlow State School's release policy and as a result, had refused Della Raye's release. In 1947, Richard Rogers had also tried to obtain his niece's release, but Superintendent Partlow had refused his request as well, stating that he did not feel comfortable with Rogers' intentions concerning Della Raye. In 1948, fearful of a threatened habeas corpus suit on Della Raye's behalf, Partlow quietly and with little fanfare released Della Raye from the hospital on January 17, 1949, under her uncle's supervision[119]

Della Raye stated that after her release, she did a lot of soul-searching concerning her feelings towards the attendants. Aware that the administration had forbidden the employees to express affection or show favoritism to any patient, she felt appreciation and affection to the few aides who had befriended her during her twenty years at the institution. She contemplated their well-being as the other aides' lives at the hospital: their illiteracy, meager backgrounds, long hours of labor, low wages, thankless jobs, and near impossible tasks. She acknowledged that their lives had been tragic. Yet, she also rationalized that her life was equal if not worse than theirs were, for she had lived it twenty-four hours, seven days a week. She too had come from a poor family, a family of

[119]Penley, 49, 132–139. Penley states that possibly, Woodruff was concerned about Della Raye's survival without her mother in the Rogers' household; therefore, she had allowed Della Raye to be committed.

sharecroppers. She had been denied an education, had been forced to work endlessly without wages, had been denied a moment of privacy, and had been denied the right to make the decision as to whether to stay or to leave. More importantly, she had been denied her mother, her childhood, and her adolescence. Ultimately, she found no room in her heart for sympathy for the aides, because no human, according to Della Raye, under any circumstances, had the right to degrade another human being.[120]

Ill from emphysema, Partlow retired as Superintendent on December 31, 1949, at which time Assistant-Superintendent Dr. James Sidney Tarwater replaced Partlow as Superintendent. One day later, January 1, 1950, the state placed the institution under the supervision of the newly created office of Mental Hygiene, managed by the Department of Public Health.[121]

James Sidney Tarwater: "Nothing Wrong ... That Money Won't Cure"[122]

Superintendent Partlow hired Tarwater as an assistant physician at Bryce Hospital in 1924. Over the next twenty years, Tarwater advanced from staff physician and staff pathologist to assistant-superintendent of Bryce Hospital. In 1948, Partlow became physically less capable of functioning as superintendent, and upon his resignation on December 31, 1949, the Board of Trustees nominated Tarwater to serve as Partlow's replacement as superintendent of the three institutions. Familiar with the earlier

[120]Penley, 217.

[121]Penley, 232. Dr. R.C. Partlow, Superintendent W.D. Partlow's brother, directed the Home as the Assistant-Superintendent until his retirement in 1965. R.C. Partlow worked for the state for fifty-three years, which included twenty-one years at the Home.

[122]J. S. Tarwater, "Superintendent's Report," Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) to the Governor with Annual Report of the Superintendent for the Year Ending September 30, 1952 (Hospital Printer), 62.

administrations' traditional dilemma of coping without adequate appropriations, Tarwater continued to abide by Peter Bryce and the subsequent superintendents' policy of moral treatment and occupational therapy.[123]

However, Tarwater's philosophy of moral treatment placed less emphasis on occupational therapy and more emphasis on research and innovative methods of treating mental illness, such as new medications, insulin shock, metrazol shock, and lobotomies. Promoting a scientific environment at the hospitals, Tarwater asserted in his article, "The Alabama State Hospitals and the Partlow State School and Hospital: a Brief History," that it was "only natural that the … interest should turn to actual psychiatric treatment, and early rehabilitation of the patient … with less patient employment."[124] With this advancement in treating the mentally ill, Tarwater and his staff also continued to use the old and inexpensive method of electroconvulsive therapy.

In his 1951–1952 annual report, Tarwater provided the traditional data on the three institutions. The weekly average expenditure per capita was eleven dollars. He stated that the Legislature had provided a supplementary appropriation of one million dollars, accompanied with ninety-three thousand dollars from the State Building

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[123]"Dr. Tarwater's Death a Blow to Alabama," *Alabama Mental Health-Retardation Review*, vol. 25 (Montgomery-June, 1974), 1. Tarwater was born on August 13, 1897 at Corona, in Walker County, the son of James Vandiver Tarwater and Emma Newton. Tarwater attended the common schools of Walker County, and received his B.S. Degree from the University of Ala. In 1922, he attended the Medical School of the University of Tennessee and received his M.D. Degree in 1923. He married Eloise Jenkins of Blount County, Ala. He was a member and former president of the Tuscaloosa County Medical Society, member of the Alabama Medical Association, Southern Medical Association, Southern Psychiatric Association, Alabama Academy of Neurology and Psychiatry and the American Medical Association. He retired form the Alabama Department of Mental Health in August 1970, at which time he went into the private practice of psychiatry.

[124]James Sidney Tarwater, *The Alabama State Hospitals and the Partlow State School and Hospital: a Brief History* (The Newcomen Society in North America: New York, 1964), 27–28. *See also* Stonewall B. Stickney, "Philosophy and Goals of the Department of Mental Health" (Department of Mental Health: State of Alabama, 1970), 18.

Commission. Of the money allocated from the Building Commission, fifty thousand dollars was for repairs and renovations at Searcy and Bryce, and forty-three thousand dollars was for the installation of attic fans at Bryce. Tarwater listed the value of Bryce Hospital as five million dollars. Searcy Hospital showed a net profit of one hundred thousand dollars of sales in farm, poultry, dairy, and animals for the year, and the Partlow Boy's Farm Colony had a net profit of ninety thousand dollars. According to Tarwater's calculations, the Searcy and Partlow institutions had a combined net worth of one-and-a-half million dollars.[125]

The two hospitals contained approximately seventy-five hundred patients: five thousand white and twenty-five hundred African-American patients. Of this total, all but two hundred white and eleven African-American patients were state supported. The Partlow State School for Mental Defectives had twelve hundred patients. Tarwater stated in his annual report that the general health of the patients was affected by the hot weather, especially among the elderly and the feeble who were confined to their beds. In addition, due to the dry, hot weather, there had been severe damage to the pastures and gardens, resulting in poor yields except for the cotton and the corn. Luckily, according to Tarwater, the hospitals had sufficient corn to provide meals for the patients and feed for the dairy and beef cattle.[126]

In reference to the nonprofessional staff, the combined total of both hospitals was one thousand employees. The male attendants received a monthly salary of one hundred

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[125]J.S. Tarwater, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) To The Governor with Annual Report of the Superintendent for the Year Ending September 30, 1952* (Hospital Printer), 8–13, 99, 121–122.

[126]J.S. Tarwater, "Superintendent's Report, 1952," 10–13.

and forty-five dollars and the female attendants received one hundred and thirty-five dollars. Tarwater also referred to the medical staff and noted that he had recently hired a dentist at Searcy. During the preceding year, two of the physicians had retired and four had resigned for various reasons. Although he had advertised for physicians, Tarwater was not optimistic about hiring anyone soon because of the pay scale; however, he responded that it was not "greatly out of line with salaries paid in other state institutions."[127]

TABLE VIII

ANNUAL REPORT OF THE BRYCE HOSPITAL

From October 1, 1951 through September 30, 1952

TITLE OF POSITION	**Quota**	**In Service at End of Year**			Appoint ments	Left Service	Vacancy at end of year
		Male	**Female**	**Total**			
1. Superintendent	1	1	-	1	-	-	-
2. Assistant Superintendent	1	1	-	1	-	-	-
3. Assistant Physicians	20	6	-	6	4	8	14
4. Dentist	1	1	-	1	-	-	-
5. Interns	5	-	-	-	1	1	5
6. Graduate Nurses:							
a. Supervisory	5	-	4	4	-	-	1
b. Other Duties	8	-	4	4	-	-	4
7. Attendants	514	241	254	495	240	189	19
8. Occupational Therapist	15	1	11	12	2	-	3
9. Recreational Therapist	6	2	4	6	6	3	-
10. Medical Clerks and Switch Board Operator	18	-	18	18	15	13	-
11. Business Office	5	1	3	4	-	1	1
12. Housekeeping Employees	54	23	31	54	22	22	-
13. Dietician	1	1	-	1	-	-	-
14. Farm Employees	56	56	-	56	7	7	-
15. Laboratory Employees	7	-	2	2	3	5	5
16. Mechanical Employees	51	51	-	51	13	10	-
17. Laundry Employees	41	-	41	41	4	2	-
18. Personnel Employees	3	1	2	3	1	1	-
19. Policemen	5	3	-	3	-	-	2
20. Psychologists	2	2	-	2	3	1	-
TOTALS	819	391	374	765	321	263	54

Source: J.S. Tarwater, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) to the Governor with Annual Report of the Superintendent for the Year Ending September 30, 1952* (Hospital Printer), 25.

[127]J.S. Tarwater, "Superintendent's Report, 1952," 10–11,

TABLE IX

ANNUAL REPORT OF THE Searcy HOSPITAL

From October 1, 1951 through September 30, 1952

TITLE OF POSITION	Quota	In Service at End of Year			Appoint-ments	Left Service	Vacancy at end of year
		Male	Female	Total			
2. Assistant Superintendent	1	1	-	1	-	-	-
3. Assistant Physicians	3	2	-	2	-	-	1
4. Dentist	1	1	-	1	-	-	-
6. Graduate Nurses:							
a. Supervisory	2	-	1	1	-	-	1
b. Other Duties	2	-	-	-	-	-	2
7. Attendants	200	100	89	189	46	35	11
8. Occupational Therapist	1	1	-	-	-	-	1
9. Recreational Therapist	1	-	-	-	-	-	1
10. Medical Clerks and Switch Board Operator	2	-	2	2	-	-	-
11. Business Office	1	-	1	1	-	-	-
12. Housekeeping Employees	31	14	16	30	16	16	1
13. Dietician	1	-	-	-	-	-	1
14. Farm Employees	17	14	3	17	3	1	-
15. Laboratory Employees	1	-	-	-	-	-	-
16. Mechanical Employees	16	16	-	16	3	1	-
17. Laundry Employees	21	-	21	21	7	7	-
18. Personnel Employees	1	1	-	1	-	-	-
19. Policemen	2	1	-	1	-	-	1
TOTALS	304	150	133	283	76	61	21

Source: J.S. Tarwater, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) to the Governor with Annual Report of the Superintendent for the Year Ending September 30, 1952* (Hospital Printer), 25.

Tarwater also included a new item in his report on Bryce Hospital, a minister's report. While asserting that modern psychiatry could make accurate diagnosis for medical treatment, Tarwater had decided to incorporate another element into his treatment methods, the use of spiritual healing. However, he went beyond the previous Superintendents' policy of welcoming outside ministers and hired an in-house minister,

one who through daily prayer and worship could gain the trust of the patients.[128]

"Chaplain, how long is soon?"[129]

According to Rev. Otis Daniel Thomas' *Through These Eyes: My Ministry to the Mentally Ill,* Tarwater hired him as Bryce Hospital's first full-time chaplain because Tarwater felt that religion could motivate the patients to follow their treatment programs, and he needed a chaplain to assist in this motivation. Thomas wrote that through his tenure at Bryce, Tarwater repeatedly remarked, "There is nothing wrong with our hospital that money won't cure."[130] While addressing the patients' anguish, Thomas' testimony also provides a perspective on the doctors' concerns on the continuity of the hospital's lack of responsibility in providing ample medical treatment to its patients, although none of the doctors acknowledge it as abuse. This information is important to the thesis in that it allows the reader the opportunity to view the perspectives of the doctors. Their testimonies strengthen the thesis' argument that patients were abused in the institutions; abused by the fact that they were constantly denied their constitutional rights to receive adequate treatment.

Born in 1899, Thomas attended Birmingham Southern College, obtained a bachelor of arts and a bachelor of divinity from Southern Methodist University, and later,

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[128]J.S. Tarwater, "Superintendent's Report, 1953," 62. According to the minister's report, although he dealt mostly with intangibles, he could report that he during the year; he had preached over one hundred sermons. He had conducted over one thousand interviews with the patients and their relatives, and had written over two thousand letters to the patients' relatives. He had also distributed over eleven thousand pamphlets to the patients.

[129]Otis Daniel Thomas, *Through These Eyes: My Ministry to the Mentally Ill* (Pelham, Alabama: The Best of Times, 1996), 44.

[130]Thomas, 8–10.

received a master's degree in sociology from the University of Alabama. Thomas entered Bryce Hospital as an employee on October 5, 1951.[131] During his orientation week, Tarwater assigned Thomas to accompany the doctors as they made their rounds on their designated wards. As a side note, with the exception of Tarwater, Thomas used false names for the hospital's personnel in order to protect the staff's privacy.

After introductions, Thomas recalled that he was startled when one of the doctors stated that he did not know about "the divinity field, but when a doctor comes to work in a mental hospital, he stoops mighty low. He stoops about as low as one can stoop."[132] Thomas indicated that most of the doctors were approaching retirement age and had abandoned their private practices to work as state employees at Bryce. He listed the professional staff as consisting of a superintendent, an assistant-superintendent, seven doctors, one dentist, eight registered nurses, and the patient census as five thousand mentally ill people. Thomas was shocked to learn that one doctor, without the assistance of psychologists or social workers had the responsibility of treating nine hundred patients. Even more daunting and unrealistic was the single dentist who worked from dawn to dusk providing services to the entire hospital's population.[133] The duties of the doctors varied according to their specialization, but, overall, most dealt with meeting with the patients' visiting kin, replying to numerous letters of inquiry from long-distance relatives who were unable to travel to the hospital, and examining their numerous

[131]Thomas, 4.

[132]Thomas, 10–11.

[133]Thomas, 11.

patients. Without question, Thomas asserted that the hospital's professional staff was an inadequate force that faced insurmountable odds.

Thomas began his tour with "Dr. Morgan," who had several hundred male patients under his care. Thomas wrote that as they walked down the ward's hallways, he witnessed men in all postures "some were half dressed, a few naked, laying on the floor motionless, while others sat still, staring into space or with drooped heads and closed eyes muttering to themselves."[134] According to Thomas, Morgan expressed his desire to help the patients, but found his task overwhelming and his efforts ineffective. When commingling with these men weeks later, Thomas learned that the patients liked Morgan; yet, he felt an undercurrent of "fear, restlessness, and hopelessness" among the men. Many asked, "If he [Morgan] did not have the time to know them then how would he know when they were well enough to go home?"[135]

According to Thomas, the patients' enemy was time. He explained that the doctors sought a source of treatment that was fast and cheap for the incoming patients, and shock treatment served this purpose. Although the hospital knew that electroconvulsive therapy (ECT) was not without problems, Thomas proclaimed the doctors routinely prescribed the therapy to new patients. "Dr. Rivers," who was in charge of the two hundred women in the Ladies' Receiving Building, was the designated administrator of the procedure. Rivers told Thomas that years earlier, under Superintendent Partlow's tenure practically every new patient had received ECT treatments, but now, Rivers only prescribed it for those who were "depressed, not eating

[134]Thomas, 13.

[135]Thomas, 76, 114.

or talking, or those who are over-stimulated and inclined to talk too loudly or push others around."[136]

Rivers' procedure consisted of ten treatments, sometimes administered at the rate of three per week. After observing Rivers during the procedure, Thomas noted that Rivers never acknowledged the female patient or attempted to explain or warn her as what to expect during or after the shock treatment. The reason for concern was that since the dosage of one hundred and twenty volts of electricity for three-eights of a second could cause convulsions powerful enough to break bones, Rivers would have the assisting nurse inject the patient just before the treatment with a muscle relaxer, which reduced the violence of the spasms. One of the problems with this procedure was the fact that the injection relaxed the involuntary as well as the voluntary muscles, resulting in a brief period of asphyxiation that required the nurse to administer oxygen immediately after the treatment. Consequently, besides feeling extreme pain and consciously suffocating, the patient later experienced "scrambled thoughts, bland facial expressions, short-term memory loss, and apathy."[137] Thomas claimed that these experiences contributed to the patients' considerable fear of the treatment, and added that during his years at Bryce, the patients often discussed their ECT experiences with him. Usually, accompanied with these discussions were prayer requests and comments such as, "Life

[136]Thomas, 19–20, 111–112. When patients arrived at Bryce, they were admitted to the Women' or Men's Receiving Building. Those who were disoriented and violent were assigned to the "disturbed" wards until they became quieter, at which time, they were moved to general wards. Patients with specific problems were gathered in designated wards, such as the tuberculosis, the criminal, or the "untidy" ward; the patients in the untidy ward were unable to control their bodily functions. Rivers was also responsible for all surgery conducted at the hospital.

[137]Thomas, 21.

wasn't supposed to be like this, was it?"[138] With a steady stream of women entering the hospital, Rivers informed Thomas that he sought to have them ready to return home within three to six months. If he judged the ECT as unsuccessful, Rivers would then transfer the patient over to the main building, where approximately two thousand women were confined.[139]

A few days into his orientation, Thomas visited with the doctors who were responsible for the female patients in the main building. When speaking with "Dr. Cutler," he told Thomas that the women's wards were similar to the men's wards except the women were more demanding. "Dr. Rolf," who cared for the female geriatrics informed Thomas that he found his position rather discouraging since he had "nothing to build on and could offer no hope."[140] Lastly, he accompanied "Dr. Alman" who was in charge of the backwards. Thomas proclaimed that this ward, where over one hundred extremely deteriorated women lived, was the most disturbing of all. In the ward, Thomas observed that a few of the women wore cotton dresses and a few were naked, but most of them wore hospital gowns and were barefooted. Alman told Thomas that the women bathed at night and received clean gowns, and after sleeping in the gowns, the women wore them the following day, until it was time to bathe again. Alman explained that every day was the same for these women.[141]

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[138]Thomas, 16.

[139]Thomas, 112, 20–21.

[140]Thomas, 115. Dr. Rolf also remarked that he was afraid of the old women and would not go among them by himself.

[141]Thomas, 117.

Thomas noted that early in his tenure he ascertained that there were no clear standards for the patients' commitment procedures. The vast majority of patients, who may or may not have been examined by a doctor, arrived at Bryce through petitions signed by their local probate judge, and were often transported by their county sheriff's department. While not mentioning whether the patients were mentally ill, Thomas did assert that few safeguards against false charges of insanity existed, resulting in an unorthodox commitment process that sent many unjustly to Bryce. Even more baffling, was the fact that the law did not restrict the commitment process to a spouse or kin, it was possible for anyone to commit an individual. Once involuntarily committed, the patient, who had no legal rights in the institution, usually remained for indefinite periods. According to Thomas, the majority of the families wanted the patients to remain for several reasons: "they either could not afford to feed them, were ashamed of them, or were unable to cope with the patients' unpredictable behavior."[142]

After ministering for fourteen years at Bryce Hospital, Thomas, who had turned sixty-six years old, had to retire. According to Thomas, although beingemployed as the asylum's chaplain had been a daunting responsibility, he still reluctantly left the asylum. In 1996, at the age of ninety-seven, he published his book on his experiences at the hospital. In his conclusion, Thomas summarized his thoughts on his experiences at Bryce. First, Thomas defended Superintendent Tarwater who he considered a role model in exemplifying motivation and efforts for the betterment of the patients through his endless requests for state appropriations. In a hospital with "unsightly wards, falling plaster, fire hazards, nasty toilets, and crowded buildings," Thomas still proclaimed that he observed

[142]Thomas, 14.

light illuminating the darkness, “excellent work against impossible odds being accomplished by good people,” a staff who manifested “a genuine interest in the patients.”[143] Yet, on the other hand, because of its insufficient quota of doctors, nurses, and attendants, many of whom were “overworked, discouraged, and poorly trained,” he also questioned the hospital’s sincerity and earnest attempt to provide care.[144] Second, and more importantly, Thomas acknowledged the patients, and asserted that the stigma of mental illness was harder to bear than “all other human afflictions and suffering.”[145] He reflected on the thousands of men and women who he had encountered over his tenure, people whose lives were wasting away, with no end to it all. One of his saddest thoughts was that every inmate, male and female, young or old, wore the same expression of despair and hopelessness. Thomas recalled what he had often heard in pray, “Oh, God, I’d rather be dead than this.”[146]

One item Thomas did not mention in his book was the four hundred African-American patients at Bryce Hospital. As a man of God, Thomas may not have seen the color of their skin. Or he may have had little contact, if any, with the African-Americans, since most of them worked in the laundry, the kitchens, or on the farms. Thomas’ memories of his 1951 initiation illustrated that very little progress had been made toward helping the mentally ill since Peter Bryce first introduced his concept of moral treatment and occupational therapy to the asylum in 1861. Except for the reduction of patients

[143]Thomas, 117.

[144]Thomas, 117.

[145]Thomas, viii–ix.

[146]Thomas, 67, 117.

working the farms, generations of patients experienced the continuity of abuse through inadequate treatment, inadequate staffing, and inadequate funds. Thomas' story also illustrated how the patients at Bryce were without legal rights to address or rectify these problems.

The Division of Mental Hygiene

The 1901 Constitution had allowed, for the most part, the superintendent and the Board of Trustees to operate and direct the asylums as they saw fit, however, after World War II, the state government slowly moved into the direction of active participation with the institutions' administrators. In 1951, the Legislature created a Special Joint Legislative Committee that investigated the administrative policies at the three hospitals. The September 11, 1951 report concluded that resident mentally ill patients did not receive periodic medical examinations; in fact, some patients had not had an exam in several years. In addition, for those few who had received examinations, the findings revealed that the hospital's physicians had not monitored their treatment programs. According to the committee, the doctors acted primarily as business managers, and the asylums' skeleton-crew of staff was clueless as to whether individual patients' conditions had improved or deteriorated.[147]

Tarwater took offense to these allegations of irregularities and mistreatment of patients. According to an article by Clancy Lake published in the *Birmingham News* in 1951, Tarwater's testimony before the legislative committee, headed by Senator Joe S. Foster, Jr., of Huntsville, stressed that the institutions' hindrances were due to lack of

[147]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1951*. (Montgomery, Ala.: Brown Printing Company, 1951), 56.

funds. On December 17, 1951, Tarwater testified that "yes, he did use shock treatments, but only after notifications to the patients' families, detailed explanations given to the family, and approval given by the family." Tarwater also stated that "the number of patients per ward varied from thirty to one hundred and forty, and the doctors would spend in the large wards each day approximately five to ten minutes." He also denied the accusations that patients were "poorly fed and had been forced to work in the rain and cold." Tarwater declared, "There has never been any authorized abuse of a patient."[148]

When asked about the fifty thousand dollars appropriated by the state to the Board because of Tarwater's request for additional funds for patient care, but, instead, Tarwater had used the money for renovations for his future home, Tarwater again took offense. According to the article, Tarwater testified that the trustees had ordered him to repair the "big home for him and his family," and argued that it was a "worthwhile move because his old home might be needed in case the hospital employed another doctor." He also added in his defense that he had halted the "distributions of vegetables in season and the Christmas turkeys to hospital trustees, county legislators, and the University of Alabama president."[149]

Administrative irregularities and the mistreatment of patients were not the institution's only problems. On April 7, 1954, Governor Gordon Persons appointed a committee to address the problem of insufficient quota of personnel at the institutions. The executive committee consisted of Superintendent J.S.Tarwater; Dr. Frank Kay,

[148]Clancy Lake, "In Bryce Inquiry-Dr. Tarwater denies abuses at hospital," *Birmingham News*, 17 December 1951. Tarwater also stated that the doctors could not stay longer in the wards due to the intense temperature.

[149]Lake, "In Bryce Inquiry—Dr. Tarwater denies abuses at hospital."

professor of psychiatry at the University of Alabama; Dr. John McKee, Director of the Division of Mental Hygiene at the State Department of Public Health; and Dr. D.G. Gill at the State Health Officer. The Governor also appointed an advisory committee, consisting of twenty-one prominent Alabama citizens, to assist the executive committee. The committee's mission was to "point out Alabama's existing mental health resources and needs, and make recommendations for improving our program for the prevention and treatment of mental illness in the state."[150] The committee's report stated that it was tragic that with new discoveries of treatments for the mental ill, the state, due to the lack of trained personnel, could not meet its responsibilities in caring for the mentally ill. According to the findings, the state mental hospitals operated with one physician to every four hundred and forty patients, (1:440). Without question, the state desperately needed to train psychiatrists and to employ more clinical psychologists, psychiatric social workers, and psychiatric nurses. In conclusion, the report emphasized the necessity of training nonprofessionals and community service staff as well.[151]

The institutions' problems of overcrowding, inadequate staff, and inadequate funding did not disappear as a result of the two investigations. However, over the next decade, some of the traditional social and political attitudes of the previous policies on the moral treatment of the patients did change. With a growing interest in mental health, there was a necessity for improved treatment for the patients. In 1962, at the Special Session of the Legislature, Act 136 created a joint legislative interim committee to make

[150]Committee on Mental Health, "Mental Health Training and Research in Alabama," 1954, 1, 5-6. Alabama Collection, Special Collections, Ralph B. Draughon Library, Auburn University, Auburn, Alabama

[151]Committee on Mental Health, 39–44.

"a study of ways and means of solving the problems of mental health and mental retardation."[152]

In 1965, under the direction of Governor George C. Wallace and at the urging of the Medical Association of Alabama, the legislators passed several Acts affecting mental health, including Act 881, a law that created the Department of Mental Health and the Alabama Mental Health Board. The act created the Department of Mental Health and the Alabama Mental Health Board as separate entities from the Department of Public Health, and designated Montgomery as the location for the Department's headquarters. The law delegated the responsibility of governing the three residential state mental hospitals and supervising the state funded community programs treating alcoholism, mental illness, and mental retardation to the Board. The Board consisted of the Governor, the seven-member Board of Trustees that had managed the Alabama State Hospitals, three members nominated by the State Committee of Public Health, and three members nominated by the Legislative Interim Committee on Mental Health and Retardation. The law required that seven of the Board members had to be licensed physicians, with a minimum of one qualified psychiatrist. The state also authorized the Board to provide for the people of Alabama such mental health services as "diagnosis of, treatment of, rehabilitation for, follow-up care of, prevention of, and research into the causes of all forms of mental or emotional illness, alcoholism, drug addiction, epilepsy, or mental retardation."[153]

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[152]Alabama, *Acts of Alabama*, 1963, 4–7. Governor John Patterson approved of the Act on January 9, 1963.

[153]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1965* (Montgomery, Ala.: Skinner Printing and Office Supply Co., 1965), 1652, 1649–1652.

Act 881 also stipulated certain duties that the Board had the obligation and authority to perform. First, the Board had the faculty set up plans to divide the state into regions, districts, areas, or zones for administrative purposes. Next, the Board was to establish minimum standards for the construction and operation of facilities, and to inspect any institution under its jurisdiction. The Board was to create a position with the title of State Mental Health Officer (Commissioner) to direct these responsibilities. The commissioner was to appoint all officers and employees and to set their salaries, to exercise the powers of the Board when it was not in session, and to carry out the Board's policies.[154] In addition, Section 19 of Act 881 stated that the state supported facilities "shall be considered an essential function of the state, and funds allocated for the support of said State supported facilities shall not be subject to proration [sic] at any time a deficit occurs in the general fund."[155]

Act 697 established that the employees of the Department of Mental Health were "subject to the rules and regulations of the State Merit System, except those employed as members of appointive boards, the commissioner, superintendents, physicians, surgeons, psychiatrists, psychologists, dentists, social worker, nurses, and attorneys." The Legislators also appropriated seven and a half million dollars to Bryce and Searcy Hospitals, a per capita of nineteen dollars per week and an additional forty-five thousand

[154]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1965*, 1649–1659. It was the responsibility of the Board to develop programs for the care of aged patients and to operate nursing homes for the elderly according to standards established by the State Board of Health. The law authorized the Board to transfer geriatric patients to private nursing homes. The Board was authorized to purchase or lease land or acquire property by eminent domain or to transfer land, buildings, or equipment in order to carry out its duties. The Board members received a fifty dollars per diem and reimbursement for mileage expenses.

[155]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1965*, 1659.

dollars for the training of psychiatric nurses. The state also appropriated two million dollars to Partlow, equating a weekly nineteen dollars and twenty-five cents per patient.[156]

With Act 654, the Legislature levied an additional privilege and license tax on the sale, storage, use, consumption, or delivery of cigarettes within the state. The revenue collected was to pay on the principal and interest on all bonds issued by the State Industrial Development Authority, and the balance thereafter paid to the General and Mental Health Fund. The collected revenue was divided into three parts: sixty percent to the State Health Officer, thirty percent to the Alabama Board of Mental Health for Bryce and Searcy Hospitals, and ten percent to the Alabama Board of Mental Health for Partlow State School.[157]

While Act 881 set into motion the creation of the Alabama Mental Health Board and the regulations for the Mental Health Department, the Alabama Mental Health Board received its greatest increase in appropriations under the supervision of Governor Lurleen Burns Wallace. In February 1967, Governor Wallace visited Partlow where she was deeply disturbed by the conditions the inmates encountered daily at the state school and hospital. Immediately, she proposed a fifteen million dollar bond as additional funding for the institutions. Once approved by the Legislature and, later, by Alabama voters, the Special Mental Health Fund added immensely to the improvement of the institutions and the weekly per capita for the patients. In addition, the Legislature allocated from the fund

[156]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1965,* 1296–97, 1412.

[157]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1965,* 1177–80.

one and a half million dollars to the Board of Trustees of the University of Alabama for salaries of professional and related personnel in its Department of Psychiatry, for the University Hospital and Hillman Clinics for the care of mental patients, and for the University's Psychological Clinic for the training of psychologists.[158]

[158]Alabama, *Alabama Laws of the Legislature of Alabama Passed at the Regular Session of 1967*, vol. 1–2 (Montgomery, Ala.: Skinner Printing and Office Supply Co., 1967), 80–83, 120–121, 678–715, 965, 1785.

CHAPTER IV. POLITICAL ISSUES INFLUENCE THE RIGHT FOR MORAL TREATMENT

Introduction

The 1901 Constitution created a tax structure benefiting the industrialists and the clique of wealthy landowners from the state's black belt region. By capping property taxes, the constitution allowed large landowners to pay very little taxes, thereby repressing state revenue. The 1901 Constitution also earmarked, designating the percentage of funds allocated to each state agency, eighty-seven percent of its revenue to certain state agencies, ones favored by the controlling body of the state government. According to Wayne Flynt's *Alabama in the Twentieth Century*, "the constitution did not empower the people; it empowered the legislature."[159] For generations, while boasting of having the nation's lowest property taxes, the state consistently allocated inadequate funds for fundamental necessities for its citizens. In order to support Alabama's growing needs, the legislators relied on taxes from sales of items such as food, gas, or cigarettes for revenue. Subsequently, as the public's need for state services grew and faced with the

[159]Wayne Flynt, *Alabama in the Twentieth Century* (Tuscaloosa, Ala.: University of Alabama Press, 2004), 15–19. "Most of the state income tax was designated to pay teacher salaries and nearly half of the state's property tax revenues to education. Gas taxes and state motor vehicle registration fees went exclusively for expenses for roads and bridges."

dilemma that Alabama's voters did not want their property taxes increased, the state legislators selected and cut the least popular budgets, such as mental health.[160]

V. O. Key's *Southern Politics in State and Nation* argues that politics without parties, without factions, rewards certain types of politicians and produces policies that are unresponsive to the needs of the poor. With the use of statistics and interviews, Key laments, "The South as a whole had developed no system or practice of political organization and leadership adequate to cope with its problems." [161] For Alabama, it had been a perpetual problem financing the state mental health institutions. For generations, the majority of legislators had invariably placed low priority on financially supporting the three hospitals, possibly because the asylums contained an invisible constituency of patients who were legally denied their right to vote. Hence, it was not a surprise to the Alabama Mental Health Board to be consistently selected for receiving less than its requested amount of funding, money for much needed administrative and rehabilitative programs.[162] One must ask; how was the Board going to finance its treatment programs much less improve its programs without proper funding? How could the mental health institutions acquire adequate staffing without adequate salaries? Lastly, how long could this discarding continue?

According to Lynda Frost and Richard Bonnie, Professors at the University of Virginia's Institute of Law, Psychiatry, and Public Policy, benevolence toward the mentally disabled was a byproduct of national political disorder. In their book, *The*

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[160]Flynt, Alabama in the Twentieth Century, 15–19.

[161]V.O. Key, Jr., *Southern Politics in State and Nation* (New York: Knopf, 1949), 04.

[162]Vickery, 159–160.

Evolution of Mental Health Law, they argue that there have been three peak movements for political reform for people with mental disabilities and those movements followed "historical moments of intense public commitment to improve the status of black people in society."[163] The first movement was around the 1820s, marking the end of the Founders' generation and the beginning of the Jacksonian Era. With this era, the states began to build residential institutions for the curative treatment for the afflicted. The second movement of reform came around the mid-1890s, a time characterized by economic depression, the growth of the Populist Party, and the fear of another Civil War. After welcoming the new millennium, the country experienced the introduction of progressive medicine accompanied with the prognosis of behavioral modification of the young. Consequently, reform came in the form of juvenile courts and state institutions for delinquents as well as for people mentally retarded.[164] Finally, Frost and Bonnie proclaim that the third movement arrived in the late 1960s and early 1970s, a time when the nation shared horrific events such as the Vietnam War, political assassinations, and race riots. According to the authors, the 1972 United States Supreme Court's *Jackson v. Indiana* decision to extend the equal protection doctrine and due process in mental health cases was the turning point for mental health law. The Court's decision "shattered the accepted

[163]Lynda E. Frost and Richard J. Bonnie, *The Evolution of Mental Health Law* (American Psychological Association: Washington, D.C., 2001), 1– 3, 18–22.

[164]Frost and Bonnie, 15–16. "Social hostility toward retardation was powerful, and parents bore a heavy load of shame, guilt, and self-mortification. An example of hostility the public felt towards the mentally retarded was the United States Supreme Court opinion, *Buck v. Bell*. In 1927, the Court upheld Virginia's compulsory sterilization law for mental defectives. Justice Oliver Wendell Holmes wrote that the law counter those who 'sap the strength of the State,' those who threaten to swamp the rest of us with incompetence, against those who will probably be executed for crimes or starve because of 'their imbecility,' whose existence should therefore be met with a pre-emptive strike." Frost states, "Obviously, the public did not want to protect, care, or view the mental deficient. The Legislature also rejected its political responsibility of providing adequate appropriations in order for the mental health hospitals to provide medical treatment to combat these ailments to provide adequate staffing, and to provide ample housing and food for the ill."

social invisibility of people with mental disabilities in judicial and legislative proceedings."[165]

In 1965, overshadowed by President Lyndon B. Johnson's Civil Rights Act of 1964, Alabama's ingrained policy of racial inequity escalated to a boiling point as it boldly challenged the nation in the legality of state rights and racial discrimination. In response to violations of the Civil Rights Act, Congress vowed that any state agency receiving federal funds, including state funded hospitals, would suffer financial repercussions. Stipulated by the racial "separate but equal" mandate and the 1901 Constitution, the Alabama mental health administrators had historically coped with an enormous financial liability concerning the daily operation of separate treatment and accommodation. Yet, the hospitals' operational problems were small in comparison to the burdens the laws had placed on the lives of its African-American patients. For generations, the hospitals' administration had assigned black patients to separate and inferior quarters, had assigned them the unpleasant chores, and had provided them with little, if any, medical treatment. Denied any legal protection or recourse, African-Americans found life difficult in the state mental health institutions. Powerless, how could these people possibly overcome generations of abusive, immoral treatment? Who would be brave enough to revolt against the institutions' legal white supremacy, but more

[165]Frost and Bonnie, 3, 18–22, The U.S. Supreme Court ruled on a case concerning a mentally ill criminal (*Jackson v. Indiana,* 1972). Following the decision, the federal district court in Wisconsin ruled on involuntary commitment (*Lessar v. Schmidt,* 1972), Alabama's federal district court issued a decree setting forth "minimum constitutional standards for adequate treatment" of residential mentally ill patients, (*Wyatt v. Stickney, 1972*), and (*Pennsylvania Association of Retarded Children v. Pennsylvania,* 1972), ruled that the state's policy of excluding children with mental disabilities from public schools and providing resources for them only in massive, geographically isolated state institutions violated the children's rights to equal protection.

importantly, who with authority would listen to the grievances of some crazy, black people? Yet, two were brave and one did listen.

Due to the courage of two brothers, the accepted policy of racial discrimination of medical treatment at Bryce, Searcy, and Partlow Hospitals came to the forefront of the nation's legal system. In 1967, the Marable brothers publicly challenged Alabama's policy of "separate but equal" by suing the state under Title VI of the Civil Rights Act of 1964 and the Equal Protection Clause of the Fourteenth Amendment. By utilizing Judge Frank M. Johnson's courtroom, the brothers called on the federal judicial system to safeguard the principles of desegregation and to ensure the civil liberties of African-American citizens in Alabama's mental health institutions. In doing so, the case was instrumental as the precursor in ending the asylums' traditional practice of immoral treatment by introducing the new Mental Health Commissioner Stonewall Boulet Stickney to the judicial sphere of Judge Frank Minis Johnson, Jr., and to the political forces of Governor George Corley Wallace, Jr.

Shortly after the decision of the federal court on the *Marable* case, another case arose, this one occurred relating to the civil rights of employees at Bryce Hospital. In 1970, a civil case filed in the United States Court for the Middle District of Alabama against the Alabama Mental Health Board sought the reinstatement of fired professionals who claimed that their dismissal from Bryce Hospital had violated their civil rights and had hindered the quality of care received by the mentally ill patients. However, according to the federal court, the scope of the case was much broader than a labor issue. The key issue was the civil suit addressed the patients' moral rights to receive constitutional and moral treatment when civilly committed to a state mental health hospital. Unforeseen, the

court, at the beginning of the litigation, came to the realization that neither state nor federal guidelines existed or had ever existed for the rights of the mentally ill or retarded. As the trial progressed, evidence of past and current abuses at the three hospitals forced the court to construct a set of minimum constitutional standards for the patients in Alabama's mental health institutions. The federal court realized that these minimum moral standards were imperative in order to guarantee involuntarily committed patients their constitutional rights of liberty and due process.[166]

The State of Alabama appealed the decree, focusing on two points: the operation of the institutions was a state issue and the federally imposed minimum standards placed an excessive financial burden on the state's taxpayers. The appeal was overruled. Consequently, the minimum standards became the first written guidelines for legal and medical professionals to follow when addressing the constitutional rights of mentally ill and mentally retarded citizens. Based on the ethos of the Fourteenth Amendment of the United States Constitution, the minimum moral standards' ruling ended generations of abuse to patients in Alabama mental health institutions.[167]

Marable v. Alabama Mental Health Board: Separate and Unequal

When Lurleen B. Wallace became Alabama's Governor in 1966, the three mental health hospitals were overpopulated, governed by Jim Crow, and under-funded. The

[166]The minimum standards also embraced the social, legal, and political issues, such as constitutional care v. custodial care, involuntary commitment v. deinstitutionalization, civil liberties of blacks v. white supremacy, and state rights v. federal judicial law, all umbrella under the issue of economics.

[167]"The Fourteenth Amendment of the United States Constitution," *The Declaration of Independence and The Constitution of the United States* (New York: Bantam Books, 1998), 83. Section 1,

residential hospitals received appropriations from the state based on the number of its patients, creating a situation that called for collecting instead of releasing patients. Alabama's institutions retained nearly ten thousand patients: Bryce Hospital, five thousand white patients and four hundred black patients; Searcy Hospital, over two thousand African-American patients; and Partlow State School and Hospital, two thousand white and black retardates. Over sixty percent of the patients at Bryce Hospital had been there between three to fifteen years, forty-two percent over ten years, twenty-seven percent over twenty years, fourteen percent over thirty years, and five percent over forty years. Yet, most other state mental asylums showed reductions in their population. For example, South Carolina had declined by nine percent; Louisiana, by twenty-seven percent; California, as high as forty-seven percent; whereas, Alabama's census had declined by only one-and-a-half percent. As for funding, even though Governor Lurleen Wallace had increased the weekly patient expenditure to forty-two dollars, when compared to other states, Alabama was substandard. For example, the Southeastern average was eighty-four dollars, and the national average was one hundred and five dollars.[168]

In addition, the hospitals operated on a segregated basis. According to state law, only black patients diagnosed as having acute impairments that resided north of U.S. Highway 80 qualified for admission to Bryce. Once admitted, they resided in segregated areas within the facility, with the main complex available only to white patients. Half of

[168]Stonewall B. Stickney, "Philosophy and Goals of the Department of Mental Health" (Department of Mental Health: State of Alabama, 1970), 3–4. See also Stonewall B. Stickney, "The Inception of *Wyatt* and the State's Response," in Jones L. Ralph and Richard R. Parlour, ed., *Wyatt v. Stickney: Retrospect and Prospect* (New York: Grune & Stratton, 1981), 12–15. Traditionally, only death released the hospitals' geriatric patients.

the hospital's four hundred African-American patients lived in Ward X (previously known as the Annex) or The Lodge which was adjacent to the main complex. The remaining African-Americans lived in two segregated buildings; Treatment Center Number Two or The Colony, both located eight miles from the main complex. Although the Partlow State School served both white and black mentally retarded patients, it was on a strictly segregated basis. Searcy Hospital, created in 1902 to house only black patients, was without question, segregated.[169]

Partially due to Alabama's insistence on racial discrimination, Congress had enacted the Civil Rights Act of 1964, an act that encompassed several sections in order to cover the various nuances of discrimination. One section of the Act, Title VI, established the fact that the national law protects persons from "discrimination, based on their race, color, or national origin, in programs that receive federal financial assistance."[170] The law continued to confirm that if an institution receiving federal aid was guilty of discrimination, the federal agency should terminate its assistance and immediately initiate legal action against the institution. The law also authorized the person discriminated against the right to file suit against the guilty party.[171]

In February 1966, the Governor's office notified the United States Department of Health, Education and Welfare (HEW) and the United States Department of Agriculture,

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[169]James C. Folsom, "The Early Constructive Approach to *Wyatt* by the Department of Mental Health," in Jones L. Ralph and Richard R. Parlour, ed., *Wyatt v. Stickney: Retrospect and Prospect* (New York: Grune & Stratton, 1981), 43. See also 297 F. Supp., "Cases Argued and Determined in the United States District Courts, United States Customs Court and Rulings of the Judicial Panel on Multidistrict Litigation" (St. Paul, Minn.: West Publishing Co., 1969), 294.

[170]"Your Rights Under Title VI of the Civil Rights Act of 1964," *Title VI Fact Sheet*; available from http://www.hhs.gov/ocr/title6.html; Internet; accessed 05 December 2006.

[171]"Your Rights Under Title VI of the Civil Rights Act of 1964.".

as it had on seven other occasions, that it had all intentions of operating the state's three mental health hospitals in compliance with Title VI, despite the fact that it still had done nothing to initiate desegregation. Attempting to follow the newly established national guidelines, Superintendent Tarwater initiated some rudimentary steps at Bryce toward desegregation. However, Governor George Wallace informed Tarwater that he was opposed to the integration, and the few patients who had been integrated were promptly "resegregated." Thus, in the summer of 1966, Tarwater informed the Regional Health Director of the United States Public Health Service that the Alabama Mental Health Board had resolved not to comply with Title VI. Faced with this open defiance of federal law by a state government, HEW began a formal investigation in January 1967. The examiner of the investigation declared the Alabama Mental Health Board to be in violation of Title VI and recommended that the United States Surgeon General and the United States Secretary of Agriculture terminate any financial assistance to Alabama's Department of Mental Health.[172]

After receiving the examiner's recommendation to terminate the funds, the state's executive and legislative branches panicked. For years, Bryce Hospital had received federal grants for the treatment of male schizophrenics and for the training of nursing aides in treating psychotic patients. These yearly grants were approximately two hundred thousand dollars, accompanied with an additional two hundred thousand dollars worth of

[172]297 F. Supp. U.S. (1969), "Cases Argued and Determined in the United States District Courts, United States Customs Court and Rulings of the Judicial Panel on Multidistrict Litigation" (St. Paul, Minn.: West Publishing Co., 1969), 296.

surplus food from the Department of Agriculture.[173] In response to the termination of this federal aid, the state Attorney General's office filed a suit against Robert H. Finch, Secretary of HEW, accusing the federal officers of acting in excess of their authority; thus, the state filed the civil action suit, *Alabama v. Finch*, which sought a declaration of state rights.[174]

Before the HEW officials could respond to Alabama's filing, Birmingham attorney Demetrius Newton filed *Marable v. Alabama Mental Health Board* on behalf of black patients and employees at the three hospitals.[175] Bert Marable, Jr., a steel mill worker from Birmingham, initiated the suit by hiring Newton to obtain equal rights for four African-American patients at the institutions. *The Montgomery Advertiser* listed the patients as Loveman Marable, Bert's brother and a patient at Bryce Hospital; Nathan Brown, Jr., of Mount Vernon, a patient at Searcy; Willie Nichols of Selma, a former patient at Searcy; and Nichols' mother, Ella MacMurray of Selma.[176] Filed in Judge

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[173]Howard L. Holley, *The History of Medicine in Alabama* (Birmingham: University of Alabama School of Medicine, 1982), 322. Holley, 322.

[174]297 F. Supp. 292.

[175]"Representative Demetrius C. Newton, Speaker Pro Tempore of the House," available from http://www.legislature.state.al.us/house/representatives/housebios/hd053.html; Internet; accessed 02 December 2006. Attorney Newton, past President of the Birmingham Urban League, ran and won a seat in the 1986 Alabama House of Representatives' election; he became the first black Speaker Pro Tempore of the House.

[176]"Suit Seeks Hospital Integration," *The Montgomery Advertiser*, 18 November 1967, p. 8. *See also* "The Obituary," *Birmingham News*, 18 November 1999, p. 7C. Born in 1919, Bert Marable, Jr., was the youngest of seven children. His parents, Bert, Sr., and Lula Marable, were literate African-Americans who had owned their own home in Birmingham. Bert, Jr., had married and had had two children, and eventually retired from the United States Steel Company. He died in 1999; his obituary listed the Sixteenth Street Baptist Church as the location of his viewing. "Ancestry.com: Discover Your Family Story," *Ancestry.com-1920 United States Federal Census*; available from http://search.ancestry.com/cgi-bin/sse.dll?rank=1&gsln=marable; Internet; accessed 20 November 2006. Loveman Marable was a man with little history. Due to a lack of records, one could only learn that Loveman was six years older than his brother, he was an African-American, and he was mentally ill.

Frank Johnson's Middle District Court in November 1967, the suit sought an injunction against racial discrimination. The filing proclaimed that Bryce Hospital separated its patients according to race, a violation of their civil rights. The lawsuit also affirmed that the state spent less money per day for the rehabilitation and the care of the patients at Searcy Hospital than it did at Bryce. Attorney Newton told reporter Peggy Roberson of the *Birmingham News* that the Board was in violation of the plaintiffs' rights under the Equal Protection Clause of the Fourteenth Amendment because the state "assigned fewer and less qualified psychiatrists, psychologists, social workers, nurses, and teachers to institutions caring for blacks than to those caring for whites."[177]

Shortly after taking the position as Alabama's new Commissioner of the Department of Mental Health, Dr. Stonewall B. Stickney learned of the Alabama Mental Health Board's litigation involving federal funding and racial discrimination in the treatment, staffing, and housing of its African-American patients. Unfamiliar with the state's political system, Stickney's reaction to the suit was that he found it "inconceivable that a state government would rather enforce racial inequity among its mentally ill patients than to receive federal funding."[178] Without regards to his career, Stickney joined

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[177]Peggy Roberson, "Mental Hospital Integration Asked," *Birmingham News*, 17 November 1967, sec. A, p. 1. See also 297 F. Supp. 293; Jack Bass, *Taming the Storm: The Life and Times of Judge Frank M. Johnson, Jr., and the South's Fight over Civil Rights* (New York: Doubleday, 1993), 151. According to Bass, Judge Frank Johnson's Montgomery courtroom had resolved most of Alabama's major racial crises, from the 1950s Montgomery bus boycott to the 1960s Selma voting rights march. Bass quotes Judge Johnson's recollection of his past legal decisions, "I believe each person is possessed of and is entitled to integrity … without regard to race, creed, color, or ideology." There was no record as to why Attorney Newton had elected to file the discrimination suit in Johnson's Middle District Court instead of the Northern District Court, but Newton had to of known of Johnson's reputation concerning on racial issues.

[178]Stickney, "The Inception of *Wyatt* and the State's Response," 9–15. Years later, Stickney testified that during this period of foot-dragging by the state on integration, hundreds of thousands of dollars in federal subsidies were lost to the state's mental hospitals. See also Stickney, "Christmas 1993," *The Harbinger*. Stickney was familiar with Searcy Hospital and its inhabitants because he visited the asylum several times as a teenager. According to Stickney, while eating homemade ice cream with his

forces with HEW in its suit against Alabama by adding the Alabama Mental Health Board and the Department of Mental Health as additional counter-defendants against the state. The suit, *The United States of America and Robert H. Finch, Counter-claimants, v. State of Alabama*, went before a three-judge panel, consisting of Circuit Judge John Godbold and District Judges Frank Johnson and Virgil Pittmans. Since compensation was not an issue in either case, the court consolidated the three cases into one, creating *Marable v. Alabama Mental Health Board.*[179]

According to Frost and Bonnie, judges, in reference to mental health cases, play an important symbolic role in court. Studies indicate that plaintiffs "place a high value on how they are treated by legal authorities and value the affirmation of their legal status as human beings entitled to be treated with dignity."[180] The judge's actions should therefore affirm the patient's humanity by informing the patients that the court is their ally, values their rights, and will treat them with fairness. These facets were in line with the court's approach in February 1969, when Judge Johnson delivered the opinion of the court.

The court ruled against the state of Alabama in the suit against HEW for withholding funds due to Alabama's practice of racial discrimination. Undeniably, African-Americans faced inferior facilities within Bryce Hospital. Built in 1892, adjacent to the laundry facility, Ward X was actually a dimly lighted, large room containing eighty-seven beds that housed the black patients assigned to work in the laundry facility. Even less acceptable to the court was the fact that the Lodge was a converted stable

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friend, whose uncle was in-charge of the facility, they would hang around the facility and watch the patients, some of them were mentally ill or disabled, but many, were simply poor and uneducated.[178]

[179]297 F. Supp. U.S. 291–293 (1969).

[180]Lynda E. Frost and Richard J. Bonnie, 302.

located at the rear of the main complex. Although the court did consider Bryce's Colony, formally known as The Gray-Stone, and Treatment Center Number Two as adequate, their location, eight miles from the main complex, was not acceptable because it clearly denied black patients several benefits. One benefit was the "open door" policy, which permitted certain patients to come and go as they pleased from the hospital to town. At the main complex, the white patients also had access to bus transportation into town, but at Treatment Center Number Two, there was no means of transportation. Another denied benefit was the lack of a canteen at the Treatment Center.[181]

The court declared that not only was it clear that the Board had exercised segregation, but it had also approved in numerous ways inadequate medical treatment for the Searcy patients. For instance, Bryce had the services of nurses in training, whereas Searcy had never had a nurses' training program. Furthermore, the black patients did not have the benefit of special psychiatric projects, such as intensive treatment for male schizophrenics. According to the court, the Board also allocated less money per patient to Searcy than to Bryce Hospital. A simple, but an important example used by the court was the fact that Bryce had traditionally received financial allocations to conduct numerous recreational programs, whereas, over the years, Searcy Hospital had received only one television set, a few decks of cards and sets of dominoes for its twenty-five hundred patients. In addition to the open apartheid of treatment towards the African-American patients, Johnson proclaimed that the hospitals' administration also practiced the "separate and unequal" theme with its professional staff. First, there were no black professional staff members, such as physicians or nurses, at either institution.

[181]297 F. Supp. 294.

Second, Bryce employed twenty-three white physicians and twenty-six white consultants for five thousand patients; whereas at Searcy Hospital, the staff consisted of one white doctor and four refugee doctors from Cuba for its twenty-five hundred patients. Johnson also notes that the record revealed considerable expert testimony to the effect that there was no medical justification for the segregation of patients or personnel since during the previous, brief time of integration, neither the white nor the black patients had experienced "trauma or acquired any illnesses." [182]

In reference to the other two claims, the court again ruled against the state of Alabama. The court indicated that the Alabama Mental Health Board had, without question, violated Loveman Marable and the other plaintiffs' constitutional rights, clearly violating the Equal Protection Clause of the Fourteenth Amendment. Neither Commissioner Stickney nor the Alabama Mental Health Board disputed the court's decision. Lastly, in response to HEW's countersuit, *The United States of America and Robert H. Finch, Counter-claimants, v. State of Alabama*, the court judged in-favor of the plaintiffs. Since the court had already judged the state of Alabama guilty of not compiling with Title VI, Judge Johnson deemed that it was not necessary to resolve the technical questions involving the state's violation.[183]

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[182]297 F. Supp. 294. According to the Court, the Board also subjected its sub-professional personnel to separate and unequal treatment. Prior to October 1966, black employees had received less pay than whites for the same work, but with the administration's new merit system, supposedly, all employees would receive the same pay. The major drawback was that due to the logistics of placing the employees into the new system, the discriminatory differential would continue until 1973. Equally unfair, according to Johnson, was the fact that the black employees at both hospitals had to eat in segregated dining areas.

[183]297 F. Supp. 297. The court modeled the relief for the consolidated case after decrees relating to public education and penal institutions: *Brown v. Board of Education*, the 1954 Supreme Court case that outlawed the "separate but equal" educational facilities for blacks and whites across the South, declared segregation a violation of the Fourteenth Amendment, and set the precedent upon which government-sanctioned segregation could be banned, *Lee v. Macon County Bd. of Education (1967),* 267 F. Supp. 458

By implementing federal authority over Jim Crow laws, Johnson triggered loud cries of judicial tyranny from state officials; according to *The Montgomery Advertiser*, Johnson, a federal judge, now controlled Alabama's state government. Although Johnson had not issued a formal injunction against Alabama, the district court did order the state to comply with the requirements of Title VI. Johnson gave Alabama officials twelve months to desegregate Bryce and Searcy Hospitals, and three months, by the end of May, to bring Partlow into compliance. By desegregating the hospitals, Johnson cemented the geriatric patients' rights to qualify for federal assistance, social security and Medicare.[184] He also ordered Commissioner Stickney and Deputy-Superintendent Tarwater to supervise the desegregation process and to provide the court with a report every six months. After receiving the court's orders, Stickney told *The Montgomery Advertiser* that he was "ready to comply" with the integration, and hoped that the hospitals would receive "more funding once desegregation was in place."[185]

However, Governor Albert Brewer, running for reelection and fearful of white voters' reaction to the order, did not implement the court's decision. In retrospect, according to Stickney's "The Inception of *Wyatt* and the State's Response," due to this foot-dragging, millions of dollars in federal subsidies were lost to the mental health

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(M.D. Ala., 1967), which enjoined the state from operating a racially dual school system, and *Washington v. Lee (1968).* After receiving Johnson's ruling, Stickney persuaded the Board not to appeal the ruling.

[184]297 F. Supp. 298–299. The court also ordered Commissioner Stickney to hire, assign, pay, and promote black employees without racial discrimination. The panel gave the Alabama Mental Health Board six months in which to present a seniority system for its employees "which does not perpetuate the effects of past discrimination against Negroes."

[185]Jim McGregor, "Mental Institutions to Integrate," *The Montgomery Advertiser*, 12 February 1969, p. 1.

institutions, resulting in less funding for treatment and staffing.[186] After George Wallace defeated Governor Brewer in November for the 1970 governor's seat, Stickney called an emergency meeting of the Board, and acting upon Stickney's suggestion, the members decided to integrate Partlow before Wallace's inauguration. The administration completed the integration within six weeks.[187]

Stonewall Boulet Stickney: Eradicating Past Moral Treatment Policies

In 1968, three years after the creation of the Department of Mental Health, the Alabama Mental Health Board continued to oversee the growing problems of the state's mental health programs without actively seeking a candidate for the Commissioner position. Arguably, this delay stemmed from the fact that neither Superintendent Tarwater nor Dr. Robert Parker, Chair of the Alabama Mental Health Board wanted to relinquish their existing authority or to change from their traditional way of doing business. According to Act 881, with the position of commissioner occupied, Tarwater would have to relinquish his authority and become the deputy-superintendent of the three residential hospitals. Nevertheless, faced with the growing problems of reconciling segregation with advances in civil rights, the growing social involvement in promoting the cause of human rights, and the increased federal rulings on state affairs, Parker began to search for a commissioner. In Pittsburgh, Pennsylvania, Parker found an able psychiatrist, Dr. Stonewall Boulet Stickney for the new position. According to Stickney,

[186]Stickney, "The Inception of *Wyatt* and the State's Response," 13. In 1972, Governor Wallace fired Dr. Stickney. Retiring from medicine, Stickney moved to Mobile and taught at the University of South Alabama.

[187]Stickney, "The Inception of *Wyatt* and the State's Response," 15.

when he accepted the position as Commissioner of the Department of Mental Health, he was a naive psychiatrist who was unaware of the controlling political forces behind the bureaucracy of Alabama's mental health institutions.[188]

Although born in Selma, Alabama, Stickney spent his formative years in Baldwin County. After high school, he left Alabama. He went to Louisiana, where he received his medical degree at Tulane and from there; he traveled to Paris, France, where he conducted his internship at the American Hospital. He returned to the States and fulfilled one year of psychiatric residency at the University of Colorado, two years as an Army psychiatrist, and two years of residency at the University of Pittsburgh. During his years of studies, he also completed seven years of psychoanalytic evaluation and training under Eric Erickson. By 1967, he lived in Pittsburgh and worked as a consultant to the U.S. Attorney's office, the United Mine Workers Clinic, and the Harmarville Rehabilitation Center.[189]

As commissioner, Stickney had taken on a huge institution and a huge problem. Stickney had the same responsibilities as that of the past superintendents, only now; he also supervised community clinics and patients who were alcoholics and drug addicts. In his first annual report, he summarized his perception of the previous superintendents' medical philosophy or policies as, "Programs here have progressed from custodial care to shock treatment during the 1930's, psychotherapy in the 1940's, tranquilizing and

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[188]Stickney, "The Inception of *Wyatt* and the State's Response," 13. Stickney focused on community awareness and early age detection of disability, by targeting children with mental disabilities as they entered pre-school or the first grade. Also, while focusing on community centers to rehabilitate the mentally ill, he amplified the need for community awareness of mental illness. Governor Lurleen Wallace died in May 1968, and Governor Albert Brewer appointed Stickney in September 1968.

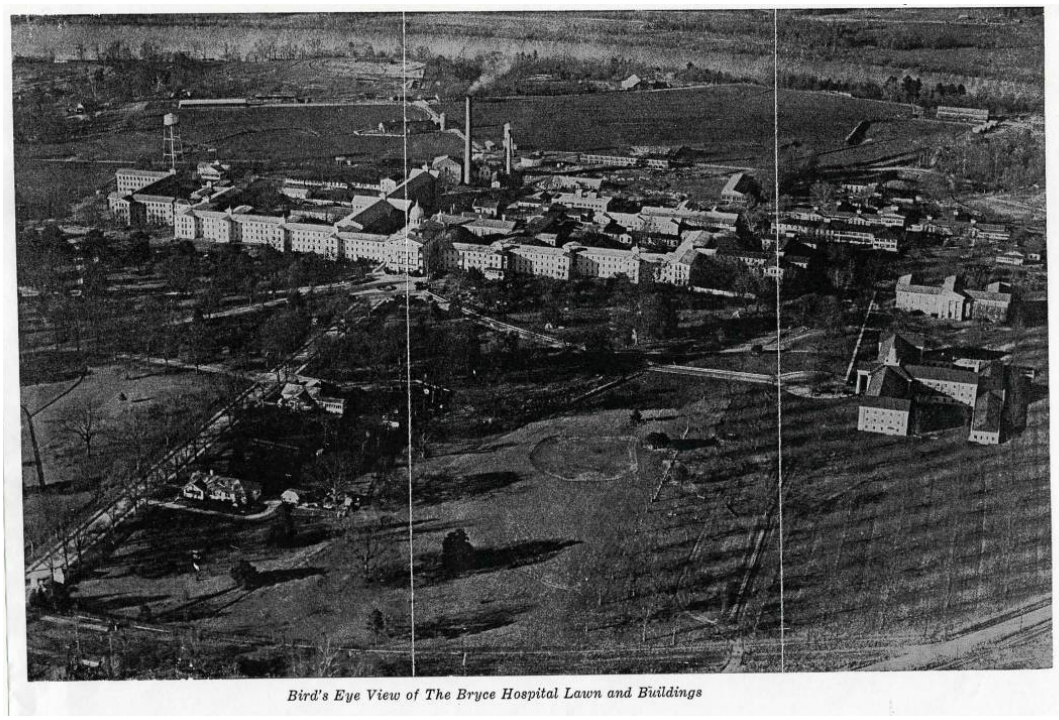
[189]Administrative files of Carl V. Bretz, Government Records, Department of Mental Health and Mental Retardation, Alabama Department of Archives and History, Montgomery, Alabama. Stickney was Board Certified in 1955.

energizing drugs in the 1950's," and as for his own contribution, he added, "to community psychiatry in the 1960's." [190] However, Stickney was different in many ways from the previous superintendents, especially in his philosophy of involuntary commitment. For one thing, Stickney disliked the practice of residential institutionalization, defining institutionalization as "apathy, lethargy, and degrees of dehumanization…that bereft [s a patient] of his civil liberties."[191] His annual report was also different from the previous superintendents. It was a short and condensed version of the previous reports. Stickney stated that the Legislature had appropriated twenty-one million dollars and combined with other monies, his funding was twenty-five million dollars. He employed seventeen hundred people and supervised ten thousand patients.[192]

[190]Stonewall B. Stickney, "The 1969-70 Annual Report of the Alabama Department of Mental Health," *Department of Mental Health Annual Report 1969-1970* (Montgomery, Alabama: Department of Mental Health, 1970), 15.

[191]Stickney, "The Inception of *Wyatt* and the State's Response," 2, 29.

[192]Stonewall B. Stickney, "The 1969-70 Annual Report of the Alabama Department of Mental Health," *Department of Mental Health Annual Report 1969-1970* (Montgomery, Alabama: Department of Mental Health, 1970), 15–43.



Bird's Eye View of The Bryce Hospital Lawn and Buildings

Figure 7. W.D. Partlow, "Superintendent's Report," *Report of the Trustees of The Alabama State Hospitals (for Mental and Nervous Diseases) To The Governor with Annual Report of the Superintendent for the Year Ending September 30, 1939.*

In reference to Bryce Hospital, Stickney wrote that the rehabilitation facility was an integral part in re-motivating the patient toward the community and his vocational goals. Under his authority, the institution had begun a new 1970 poultry unit that consisted of eighteen thousand laying hens. The two farms, consisting of pasture, cultivation, and timber, produced a total income of three hundred and forty thousand dollars of which one hundred and seventy-four thousand dollars was cash sales and one hundred and sixty-six thousand dollars was fair market value for produce and dairy products used at the institution.[193] Stickney also referred to the Department of Pastoral Care and Education, which consisted of four full-time chaplains, one secretary, one part-

[193]Stonewall B. Stickney, "The 1969–70 Annual Report of the Alabama Department of Mental Health," *Department of Mental Health Annual Report 1969-1970* (Montgomery, Alabama: Department of Mental Health, 1970), 35.

time organist-music assistant, and a continuous training group of five to ten clergymen in Clinical Pastoral Education. Stickney wrote that during the past year, the pastors had conducted approximately fifty religious services each month, involving more than four thousand patients. The Bryce Touring Choir, composed of thirty patients, sang each Sunday at the Protestant Worship Service and toured the state, giving concerts in different communities each month. In conclusion, Stickney briefly referred to Searcy and Partlow's financial status and patient load.[194]

New Administrative Decisions

With the *Marable* suit over, Stickney made a major administrative decision concerning the traditional procedures of moral treatment at the three hospitals. Stickney hired Dr. James Folsom, Director of the Tuscaloosa Veterans Hospital as a consultant to provide insight on how to improve the conditions and to lower the census at Searcy Hospital. He choose Folsom because he was impressed with Folsom's success in using the "unit" and "reward system" of attitude behavior modification at the VA Hospital. He selected Searcy Hospital for two reasons: having visited it several times as a youth, he had sentimental feelings for the hospital and its patients, but more importantly, he could exercise more control over the hospital's policies without combating the old guard, the doctors and the University of Alabama's staff that he encountered at Bryce.[195]

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[194]Stonewall B. Stickney, "The 1969–70 Annual Report of the Alabama Department of Mental Health," *Department of Mental Health Annual Report 1969-1970* (Montgomery, Alabama: Department of Mental Health, 1970), 35–36.

[195]Stickney, "The Inception of *Wyatt* and the State's Response," 15. Dr. James Folsom, a native of Marengo County, had obtained graduate training at the University of Vienna and The Menninger Institute in Topeka, Kansas, and had served as the Director of the Veterans Administration Hospital in Tuscaloosa.

With Commissioner Stickney's approval and encouragement, Folsom fostered several innovative changes at Searcy. Months later, while pleased with Folsom's methods and productivity, Stickney was aware that they were costly and came with resentment and rebuttal from the doctors at Bryce, especially those affiliated with the University. One reason for the animosity was Folsom's tactics of improving the patients' personal hygiene, a method that required an increased need for aides and a less need for professionals. Another reason for internal turmoil was the fact that after Tarwater had retired, Stickney had appointed Folsom as the new deputy-superintendent, an appointment that had obviously displeased both the Bryce and Partlow administrators. Nevertheless, with Folsom on board and happy with the ensuing benefits for the patients at Searcy, Stickney hoped to expand the modern programs to Bryce and Partlow. Thus, Stickney requested a substantial increase in appropriations from the state Legislature.

Request for Adequate Funds

Shortly after becoming commissioner of the Department of Mental Health, Stickney learned that for generations the Board of Trustees had routinely petitioned a budget to the Legislature requesting a low sum of money, and the legislators in turn, had granted an ample portion of the requested sum. The obvious question is; why did the Board do this? Because the Trustees knew their "place" and accepted the fact that the lawmakers were not interested in the hospitals' inadequate conditions or its indigent inhabitations, the majority of whom could not vote. Hence, in the summer of 1970, after breaking from tradition by requesting a substantial increase in funding for the Department

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Also the Board had empowered Stickney to move 600 people from Bryce to Searcy and an equal number from Searcy to Bryce.

of Mental Health, Stickney received notification from the Legislature of a lower than usual allocation of requested funds, approximately six hundred thousand dollars less. The legislators stated that due to a five percent across-the-board raise to merit system employees, they had no choice but to reduce their standard allocation of tobacco tax revenues to the Alabama Mental Health Board.[196]

Although aware that his involvement with the federal government in the *Marable v. Alabama Mental Health Board* case had seriously jeopardized his relations with the Legislature, Stickney was baffled by the Legislature's reduction of appropriations. He was equally frustrated with the power of the old guard of professionals at Bryce Hospital who had constantly impeded his attempts to implement new treatment and staffing policies at the hospital. Thus, Stickney decided to create a crisis, a crisis that would resonate all the way up the political ladder to the governor. Stickney cut his Department's budget by one percent and laid-off ninety-nine Bryce employees, twenty of whom were psychologists, social workers, and occupational therapists associated with the University of Alabama. According to Stickney, the insensitive manner in which he and the new Deputy-Superintendent Folsom dismissed them was insulting and more than they could tolerate. In his article, "The Inception of *Wyatt* and the State's Response," Stickney proclaimed, "It was an opportunity to shake up the staff at Bryce and allow new leadership to emerge, while dramatizing to the governor, legislature, and citizenry the miserable conditions in Alabama's mental institutions."[197]

[196]Stickney, "The Inception of *Wyatt* and the State's Response," 15.

[197]Stickney, "The Inception of *Wyatt* and the State's Response," 15–20.

According to Stickney, after the September firings, a consensus of protest immediately arose from the University's Department of Psychology, demanding the dismissed staff's reinstatement because the University needed the staff for training its psychology interns, social workers, and special education teachers. Stickney claimed it disturbed him that the University was more concerned with losing its training and research projects than it was with the immoral conditions at the institution. Stickney commented, "I have learned from mental health officials in other states that this kind of rivalry between state universities and departments of mental health is not uncommon, though no less immoral."[198] Contrary to Bryce's traditional practice of little concern for a hands-on patient therapy, both Stickney and Folsom supported and promoted a great deal of emphasis on attitude therapy combined with a daily hygiene treatment plan administered by paraprofessionals. Even more controversial was their implementation of the "unit" system, a method of assigning white and black patients from the same geographical area in the state to a particular unit in the hospital.[199] Many considered it unacceptable because it required desegregation. Although the Alabama Board of Mental Heath had been ordered by the federal court in February 1969 to desegregate the three hospitals, the Board had yet to implement the ruling at Bryce or Searcy.

[198]Stickney, "The Inception of *Wyatt* and the State's Response," 21.

[199]James C. Folsom, "The Early Constructive Approach to *Wyatt* by the Department of Mental Health," in Jones L. Ralph and Richard R. Parlour, ed., *Wyatt v. Stickney: Retrospect and Prospect* (New York: Grune & Stratton, 1981), 43.

Wyatt v. Stickney

As for the cutbacks, several of the fired professionals felt Stickney had overstepped his authority. Dr. Raymond Fowler, a specialist in correctional psychology and head of the Psychology Department at the University was among those most enraged by Stickney's dismissal of the Bryce staff. Fowler, along with several of the dismissed professionals, decided to file suit against Stickney and the Alabama Board of Mental Health. To add strength and credence to their allegations that the patients' treatment would suffer because of their termination, they decided to incorporate a few mentally ill patients as supplementary plaintiffs to the class action suit. Mrs. W. C. Rawlins, one of the fired aides, had a sixteen-year-old nephew, Ricky Wyatt, who was a patient at Bryce.[200] The professionals' attorneys, Jack Drake and George Dean who had not met Ricky, selected the sixteen year old as the lead plaintiff. Dean filed *Wyatt v. Stickney* in the United States District Court for the Middle District of Alabama against Alabama Mental Health Board and the State of Alabama on October 23, 1970. The complaint alleged that the Board had fired the ninety-nine employees for budgetary reasons and had discharged them without notice or a hearing, thereby violating their rights under the Fourteenth Amendment's due process clause. In addition, the suit stated that as a result of the professionals' dismissal, the patients at Bryce would not receive adequate treatment. The complaint sought injunctive relief requiring the defendants to rescind the termination of the ninety-nine employees and to prohibit the defendants from "interfering with, interrupting or changing the present course of mental health treatment and services now

[200]Dean knew that Wyatt was the same age of Judge Johnson's son who was also in and out of private mental health institutions.

being given to plaintiffs."[201] Learning of the suit, Stickney commented that the motivating power behind the suit was a "small number of staff and some civil rights lawyers, sad to say, not a group of indigent patients or their relatives. Most state hospital patients … are usually from low socioeconomic levels, have little education, and have no power or connections."[202]

Presiding over the class action suit was Federal Judge Frank Johnson. Johnson ruled against the fired plaintiffs, stating that the Alabama Mental Health Board did have the legal right to lay-off its employees when faced with budgetary difficulties, therefore, the Board had not violated the employees' rights of due process. However, in his chambers, according to Jack Drake's interview with the *Yale Law Journal*, Johnson informed Dean that there was cause for concern over the mentally disabled patients' rights to "adequate and moral treatment," stated by the implication that "under the new conditions at Bryce, the loss of staff, any patient committed involuntarily for treatment would suffer incarceration without the benefit of due process of law."[203] Simply stated, the patient's right to treatment is the opportunity, obliged by the state, to receive an honest attempt of treatment under civilized conditions. Sensing Johnson's urgency on the question of adequate treatment, Dean changed the focus of the litigation from the staff terminations to the patients' grievances of inadequate treatment at Bryce hospital. On January 4, 1971, Dean amended the original complaint by requesting that the defendants

[201]Wyatt v. Aderholt, 503 F. 2d 1305, 1308. Dean selected Johnson's court instead of the Northern District of Alabama federal court. Dean never met Ricky. Dean was familiar with Judge Johnson's sixteen year-old son who was also mentally disturbed and committed at various times to out-of-state, private mental institutions.

[202]Stickney, "The Inception of *Wyatt* and the State's Response," 21.

[203]"The Wyatt Case: Implementation of a Judicial Decree Ordering Institutional Change," 84 *Yale Law Journal* (1975): 1338. *See also* Wyatt v. Stickney, 325 F. Supp. 781–784.

cease operating Bryce "in a manner that does not conform to constitutional standards of delivering adequate mental treatment to its patients," with the stipulation that the patients who were involuntary committed to a state mental health facility were sanctioned to "adequate, competent treatment."[204]

The district court ruled on the motion of plaintiffs for preliminary injunction on March 12, 1971. As for the facts underlying the decree, the court observed that Bryce Hospital housed approximately five thousand white patients, mostly involuntarily committed by various Alabama probate judges. Of the five thousand, there were sixteen hundred geriatric patients and one thousand mental retardates who had not received any psychiatric treatment, only custodial care. As for the available medical staff to treat these five thousand patients, there were seventeen physicians, twelve psychologists with varying academic qualifications and experience, twenty-one registered nurses, thirteen social service workers, twelve patient activity workers, and approximately nine hundred psychiatric aides. Of these employees there was one clinical psychologist, three medical doctors with some psychiatric training, and two social workers whose duties involved direct therapeutic patient care. Overall, the staff to patient ratio was one to five, 1:5.[205]

Since the patients at Bryce Hospital, for the most part, were involuntarily committed through non-criminal procedures, they were, according to Johnson, committed without due process of law, guaranteed by the Fourteenth Amendment. Johnson claimed that treatment was the only justification, from a constitutional standpoint, that allowed a person to be involuntarily committed to a mental institution. In addition, adequate and

[204]Wyatt v. Aderholt, 503 F. Supp..2d 1305, 1308.

[205]Wyatt v. Stickney, 325 F. Supp. 781–783, 784.

effective treatment was constitutionally required because if the hospital was without treatment, it then transcended "into a penitentiary where one could be held indefinitely for no convicted offense."[206] Consequently, Judge Johnson ruled that the patients:

> unquestionably have the constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition…to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. What is involved in this case is…the very preservation of human life and dignity.[207]

Going beyond his official duties, Johnson became involved with the administrative procedures at Bryce Hospital. The court ordered Commission Stickney, the Alabama Mental Health Board, and the state to prepare a "comprehensive constitutionally acceptable plan to provide adequate treatment in any state mental health

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[206]Wyatt v. Stickney, 325 F. Supp. 784. The court referred to *Rouse v. Cameron*. Charles Rouse, aged 17, was arrested in Washington, D.C. for carrying a loaded pistol and some ammunition. He was acquitted by reason of insanity and was awarded an indeterminate sentence at St. Elizabeth's Hospital, where he remained for over four years. When his Legal Aid was unsuccessful in getting him free in Federal District Court, he appealed and went before Judge David Bazelon, an activist judge. Bazelon sent the case back to the lower court with the injunction to look into the question of whether or not Rourse had been deprived of his "right to treatment." Rouse's attorney, Charles Halpern who as a young attorney had been impressed with courses on psychiatry and the law at Yale Law School, elaborated on the "right to treatment" concept. He pointed the anomaly of keeping somebody confined with no treatment and suggested constitutional issues were at stake. The case was released on a technicality before a decision was made. However, the argument stirred speculation in legal precincts that mental institutions need not be off limits to lawyers. According to Halpern, conceptually and legally, the right to treatment was incomplete without the right to the least restrictive alternative (treatment), and ultimately, the right to refuse treatment.

[207]Wyatt v. Stickney, 334 F. Supp., 387, 395–407. See also Committee on the Office of Attorney General, "The Right to Treatment in Mental Health Law" (Raleigh, North Carolina: National Association of Attorneys General, 1976), I; Morton Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). In 1960, Dr. Morton Birnbaum, an attorney and physician, argued in the American Bar Association Journal that persons involuntarily committed to mental institutions have a "right to treatment;" Tinsley E. Yarbrough, *Frank Johnson and Human Rights in Alabama* (University, Ala.: University of Alabama Press, 1981), 170. Yarbrough states that Attorney-physician Morton Birnbaum's "The Right to Treatment" published in 1960 argues that each mental patient had a legal right to such treatment as would give him "a realistic opportunity to be cured or improve his mental condition." Failing that, Birnbaum argues the patient should "obtain his release at will in spite of the existence or severity of his mental illness." Birnbaum did not see the latter as a way to achieve deinstitutionalization, but rather as an enforcement mechanism to impel improved hospital treatment. Attorney George Dean, decided to use Birnbaum's thesis of a "right to treatment" as the basis for his suit and Birnbaum himself became co-counsel for the plaintiffs.

facility within three months." Johnson also gave Stickney six months to implement a "fully appropriate mental health program" at Bryce Hospital. [208] Johnson informed the defendants and plaintiffs that although he was not opposed to the unit system, he was not convinced that it would provide adequate treatment at this time for the state's involuntarily committed patients. Therefore, at the six-month review, if he deemed Stickney's programs as inadequate, he would appoint a panel of mental health experts to determine the mandatory standards required in order to furnish adequate treatment. Lastly, Johnson requested the services of two federal departments as *amicus curiae*: the United States Department of Justice and the Department of Health, Education, and Welfare. The Justice Department was to assist in gathering evidence of conditions at the institution, and HEW was to assist in qualifying the sixteen hundred geriatric patients for Social Security benefits and in placing them in nursing homes.[209]

Abiding by Johnson's request, Stickney, along with Folsom outlined a three-phase program for quality treatment. Based on his article, "Philosophy and Goals of a Mental Health Department," the report defined the patients' rights to receive medical treatment once institutionalized. It also encapsulated three issues**:** individualized treatment plans, qualified staff in numbers sufficient to administer adequate treatment, and humane psychological and physical environments. It concluded with the assertion that community awareness and appropriate services for the mentally disabled could result in several

[208]Wyatt v. Aderholt, 503 F. 2d 1305, 1308. The first case to recognize the right to treatment was *Rouse v. Cameron* that suggested that there are constitutional objections to involuntary commitment (whether civil commitment, incompetence-to-stand-trail commitment, insanity-defense commitment, or incompetence-to-serve-a-sentence commitment) without treatment. See also *Wyatt v. Stickney*, 325 F. Supp. 786.

[209]Wyatt v. Stickney, 325 F. Supp. 786. See also "The Wyatt Case," 84 Yale Law Journal, 1338, 1365.

advantages for the community, such as a favorable impact on public schools, the families of the mentally ill, and the general attitude of the people of Alabama as it related to the mentally ill. More importantly, the plan would facilitate change and "the quality of life experienced by the patients would unquestionably be better."[210] Stickney submitted the report to the court in June 1971.

In conjunction with writing the report, Stickney and Folsom immediately organized and implemented their unit plan at Bryce. In the past, the buildings used for receiving the male and female patients were gender segregated and were located at different areas of the campus. However, under Folsom's authority, the new patients were assigned to the intensive treatment unit, based on a co-ed system, to the most modern buildings, newly equipped with air conditioning. According to Folsom's interview with the *Birmingham-Post Herald*, the first floor was for men and contained some private rooms equipped with heavy-duty doors for unruly patients. On the same floor, Folsom had a former dining room transformed into a table tennis room. The second floor was for the female patients. The rooms contained two beds, a wooden chair, and a small table for the patients' personal belongings. The third floor was more open and consisted of large rooms with twenty-four to thirty-six beds in each room. For those patients assigned to this floor, they received a small box for their private belongings and the boxes remained in a locked closet at the nurses' station. Finally, on the fourth floor, beds line the walls, set two and three deep with a television in the center of the room. Believing that it was

[210]Stonewall B. Stickney, "Philosophy and Goals of the Department of Mental Health" (Montgomery: Department of Mental Health, 1970), 25–49. See also Stonewall B. Stickney, "The Inception of *Wyatt* and the State's Response," in Jones L Ralph and Richard R. Parlour, ed., *Wyatt v. Stickney: Retrospect and Prospect* (New York: Grune & Stratton, 1981), 21 Unfortunately, Stickney and Folsom's proposal depended on seventy-five percent federal funding by the U. S. Department of Public Services. The guidelines that defendants, Stickney and Folsom had proposed were the references Johnson later used for the court's minimum standards. These standards later became known as the Wyatt Standards.

necessary to get the patient back into to society as quickly as possible, Folsom projected the patients stay at the intensive unit to be three months and prescribed therapy accordingly. Otherwise, according to Folsom, the longer the patients stay at the facility without treatment, the more likely the patients would never leave the hospital. [211]

Folsom also incorporated the reward system, such as the freedom to go into Tuscaloosa to shop, as a method of reintroducing the patients into society.[212] As an additional component of therapy, the staff used the reward programs to motivate the patients to perform daily chores, such as giving them cigarettes for making their beds or candy for staying out of bed. There was also the token system, in which patients would receive tokens for performing tasks: three for bathing every second day, one for brushing their teeth, and one for taking their medicine. Folsom allowed the patients to use their tokens to purchase items in the canteens.[213]

Since the court had granted Dean's motion to add the patients involuntarily committed at Searcy Hospital and Partlow State Hospital and School to the class action suit on August 22, 1971, Folsom now had the three hospitals to conform to his application of attitude therapy.[214] Folsom divided Alabama's sixty-seven counties into half, assigning the northern counties to Bryce Hospital and the southern counties to Searcy Hospital, therefore, Searcy had to transfer patients to Bryce and vice versa. A

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[211]Carol-Faye Bruchac, "From the outside, Bryce looks like any typical campus," *Birmingham Post-Herald*, May 18, 1971, p. 7.

[212]Carol-Faye Bruchac, "Treatment programs have almost reversed in last 6 months" *Birmingham Post Herald*, May 20, 1971.

[213]Carol-Faye Bruchac "Staff was the only place left where expenses could be cut," *Birmingham Post Herald*, May 19, 1971, p. 5.

[214]Wyatt v. Stickney, 334 F. Supp. 1343.

revolutionary event, according to the *Birmingham Post Herald*, that created much excitement among the staff and patients, for some patients had been residents at their respective institution for over forty years, not to mention that they had never encountered desegregation.[215]

Folsom divided Bryce Hospital into eight units to contain the state's top thirty-four counties. The Jefferson County unit, which also included Blount and St. Clair counties, consisted of three buildings, two for women and one for men. Carol-Faye Bruchac's news article "From the outside, Bryce looks like any typical campus" described the Jefferson county unit as consisting of fifteen wards, each building holding approximately three hundred and fifty patients. The wards, divided into cubicles with six beds to each cubicle, also provided a private visiting room and a dayroom containing a television.

After arriving at their new hospital, the patients, both white and black, received new guidelines outlining the concept of the unit system. Under the new system, the patients' illness, age, or color of skin did not determine their ward allocation or ward classification, such as back wards or dirty wards; these terms were no longer applicable. Now, the residents simply resided in a unit according to the county of their home address. Folsom told the *Post Herald* that the reasoning behind the county allocation was the theory that if patients were surrounded by other patients of a general local, it would assist the patients in maintaining their identity, facilitate the patients' reentry into their

[215]Bruchac, "Treatment programs have almost reversed in last 6 months".

community, and allow for social workers and community volunteers of the respective counties to become acquainted with the individuals before they returned home.[216]

On September 23, 1971, the court listened to testimony from the Bryce staff that participated in implementing the unit program. The staff included two foreign-born psychiatrists who were in training at Bryce. As of yet, they did not have an Alabama State license because according to Alabama law, state hospitals could hire foreign-born personnel until they had passed their state boards, a practice that allowed the state to pay them lower salaries than licensed doctors. Mrs. Virginia Williams, the only registered nurse at the Jefferson unit, with the aid of one assistant oversaw the functions of the professionals and one hundred aides. The rest of the staff for the Jefferson County unit were two social service workers, a student chaplain, a patient activities worker, two part-time rehabilitation workers and two consultants. Complicating the labor issue was the fact that the nonprofessional staff consisted of poorly trained laborers who were also understaffed and overworked. Thus, according to the witnesses, it created not only an inadequate treatment situation for the patients, but also, an extremely stressful situation for the hospital's personnel.[217]

According to Dr. Gonzalo Ochoa, the Jefferson County unit's senior staff psychiatrist, the unit would require the services of three psychiatrists and possibly four persons with psychiatric experience, and five to six times the amount of staff than what they currently had in order to practice Stickney and Folsom's plans. Once the hospital

[216]Bruchac, "From the outside, Bryce looks like any typical campus," p. 7.

[217]Bruchac, "Staff was the only place left where expenses could be cut," p.5. Second in size to Jefferson County was the Tennessee Valley area, containing approximately five hundred patients from seven counties.

had the staff in-place, he testified that he would need at least three months of organization before he could start the prescribed programs. Concerning the paraprofessionals, he stated that few people applied for employment because the aides' salary was so low, and what few did apply were mostly females because men could find better paying jobs. Ochoa concluded his testimony by stating that even if new aides were hired, there would be no one to train them; therefore, in his opinion, it was a hopeless situation. [218]

On October 13, 1971, the reports filed by the plaintiffs and the *amicus curiae* reflected previous statements on the deficiency of medical treatment and the demoralizing features of the hospital. For example, the toilets in restrooms seldom had partitions between them, a dehumanizing factor that degenerated the patients' self-esteem. According to Dean, the psychological environment was also non-therapeutic because the staff consistently assigned patients to perform uncompensated housekeeping chores.[219] Johnson ordered the court to reconvene on November 15, 1971, in order for the attorneys for the Departments of Justice and of Health, Education, and Welfare to call on witnesses to testify on the conditions at the three institutions.

One of the witnesses for the Justice Department was newspaper writer Paul Davis of the *Tuscaloosa News.* Davis had written articles about the terrible conditions at the Hospitals for years and had sent each published article to Judge Johnson. Davis was highly critical of the existing conditions at Partlow. When interviewed thirty years later on his view of the doctors' efficiency and sincerity, Davis stated that the hospitals'

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[218]Bruchac, " Staff was the only place left where expenses could be cut," p. 5. See also Carol-Faye Bruchac, "Short-handed Bryce faces count deadline of Sept. 1," *The Birmingham Post Herald*, May 17, 1971. The salary was three hundred dollars a month for provisionary workers, ones who had done poorly on the job application test and four hundred dollars a month for the average worker.

[219]Wyatt v. Stickney, 334 F. Supp. 1343.

professionals considered the patients as "things, things that could be discarded." He also commented that Governor Lurleen Wallace had been to his knowledge the only "official who took the time to walk along the backwards of the institution."[220]

At the end of the testimony, Johnson called for a future hearing at which time he would deliver the court's decision on whether the hospitals provided adequate treatment for the patients. In addition, he changed the course of the trial for the second time. Johnson invited several organizations to become *amicus curiae,* such as the American Psychological Association, the American Ortho-psychiatric Association, the American Civil Liberties Union, the American Association on Mental Deficiency (now the American Association on Mental Retardation), the American Psychiatric Association, the National Association for Retarded Citizens, and the National Association for Mental Health. He requested that they actively participate in the court procedures and welcomed their comments and perspectives on the Alabama Mental Health Board's accepted methods of moral treatment.[221]

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[220]Paul Davis Interview, November 20, 2007, Tapes in possession of author.

[221]Wyatt v. Stickney, 334 F. Supp. 1341, 1342-3. See also "The Constitution v. the snakepit: How lawyers are proving that mental inmates have a right to treatment" by Walter Goldman. March 17, 1974 *New York Times*, ProQuest Historical Newspapers, *The New York Times* (1857–2003), 256. Among the lawyers representing these amicus were Charles Halpern, who in 1966 had set up the Center for Law and Social Policy; Paul Friedman, a Yale Law School graduate whom Halpern had recruited for the center with a view to enhancing its efforts in the mental health field; and Bruce Ennis, a University of Chicago Law School graduate who had left a Wall Street law firm in 1968 to head up a mental health law effort being started by the New York Civil Liberties Union. They helped to organize the Mental Health Law Project, with the goal of developing a cadre of lawyers to specialize in the field, educate the public, state legislature, and Congressional committees on mental health.; http://www.psychlaws.org/Legal Resources/CaseLaws/Case 5.htm accessed January 24, 2005. Wyatt v. Stickney 325 F. Supp 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala 1971), 344 F. Supp. 373 (M.D. Ala. 1972), Sub nom Wyatt v. Aderholt, 503 F 2d 1305 (5th Cir. 1974). Bruce Ennis worked on *Wyatt* along with Charles Halpern, Paul Friedman, Margaret Ewing, and Morton Birnbaum. Birnbaum wanted to challenge the constitutionality of the 1965 Medicaid legislation, excluding state mental hospital patients under sixty-five from Medicaid benefits. Because of Medicaid's matching provisions, he calculated that if Medicaid included state mental hospital patients, Alabama would be able to quadruple its expenditures on these patients without increasing state appropriations. Ennis, attorney for one of the groups believed the state mental institution system was

On December 10, 1971, the court ruled three points. First, due to the testimonies and evidence, the court deemed Folsom and Stickney's unit treatment programs as currently unacceptable. Second, due to the lack of quotas and training, the staff was inadequate. Third, the Board did not have nor had it ever had a guideline of minimum standards for the adequate treatment of the mentally ill. Due to the past testimonies, the court was not surprised with the first two points; however, the third point was perplexing. Johnson expressed the seriousness of the lack of constitutional rights of the patients and the extreme need for fairness and protection of the patients' civil rights. Consequently, the responsibility to formulate a set of standards, according to Johnson, fell on the shoulders of the court. However, before starting this project, Johnson wanted the professional feedback of the experts, mostly from the *amicus curiae*, of what adequate moral treatment entailed while stressing the point that he thought the standards should follow the three points outlined in Stickney's "Philosophy and Goals of a Mental Health Department." The court set the case for formal hearings on February 3, 1972. On that date, both the defendants and *amicus curiae* were to present proposals that would qualify as adequate medical and constitutional standards for the mentally ill and mentally retarded.[222]

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ineffective and deprived people of their liberty. He did not believe in the 'right to treatment' concept because it legitimized involuntary confinement. The Project worked to restrict involuntary treatment and to create the right to refuse treatment. Birnbaum quickly fell out with Ennis and the others as the prospect of Johnson moving in their direction of thinking became a reality. Birnbaum proclaimed that Johnson's decision of minimum standards created "almost insurmountable" financial problems that could only lead to the discharge, "dumping," of thousands of patients from residential hospitals with no alternative facilities in place to care for them. In 1972, Birnbaum bowed out of *Wyatt v. Stickney* to initiate a challenge in federal court in New York to the Medicaid exclusion.

[222]Wyatt v. Stickney, 334 F. Supp. 1341, 1342-3 (1971).

On February 3, 1972, Dr. Phillip Roos, executive director of the National Association for Retarded Children, recalled his visit to Partlow for the court. Besides the cockroaches and the broken toilet seats, he also found ill-trained attendants who thought the children were incapable of understanding or developing. Hence, they used cattle prods to motivate the children. He stated, "The conditions, I would say, are hazardous to psychological integrity, to health, and in some cases even to life."[223] He continued by arguing that a mentally retarded individual shared the same basic human needs for privacy, affection, and dignity as that of a normal person. According to Roos, normality was an impossible quest at Partlow because of its assembly line meals and car-wash showers, arrangements that worked against "the development of personality and independence and have the effect of dooming the more salvageable to steadily deteriorating lifetimes in the institutional mode."[224]

The American Association on Mental Deficiency's evaluation reported their observation of nine working residents at Partlow who feed fifty-four young boys food from one very large bowl with nine plates and nine spoons. The aides also put patients in straitjackets; they viewed one resident who had been confined in a straitjacket for more than nine years. According to other testimonies, aides without orders would frequently put patients in secluded rooms that were large enough for only one bed and a coffee can, the can serving as a toilet. The witnesses claimed that patients with open wounds and

[223]Walter Goldman, "The Constitution v. the snakepit: How lawyers are proving that mental inmates have a right to treatment," March 17, 1974, *New York Times*, ProQuest Historical Newspapers, *The New York Times* (1857–2003), 256.

[224]"The Constitution v. the snakepit," 256.

inadequately treated skin diseases were in imminent danger of infection because of the wards' unsanitary conditions, such as urine and feces on the floor.[225]

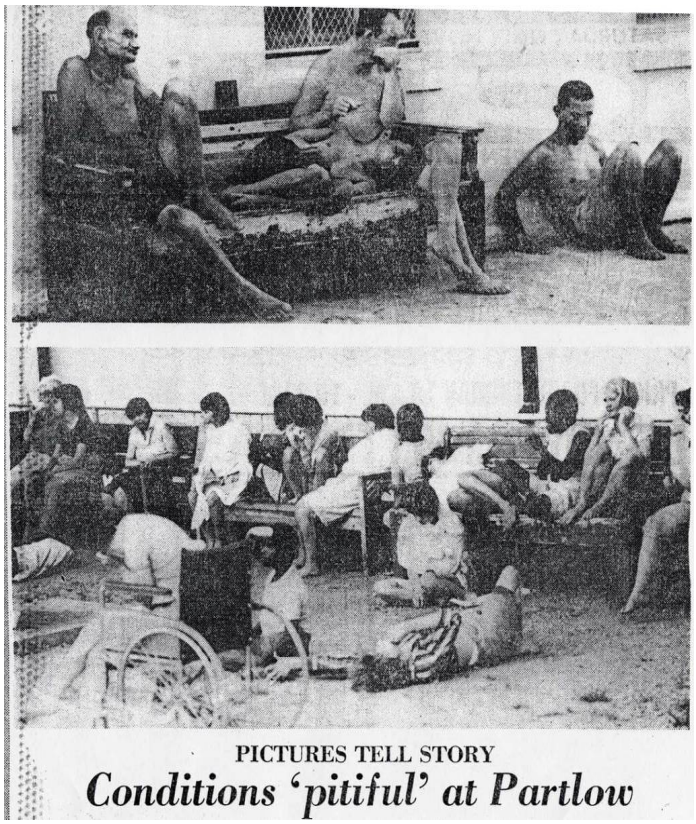

Figure 8. Stan Bailey, "Conditions 'pitiful' at Partlow," *The Alabama Journal*, August 10, 1971.

After hearing several testimonies, Johnson stated that the evidence showed that the mentally disabled had received immoral treatment and were without safeguards to

[225]Wyatt v. Aderholt, 503 F. 2d, 1305, 1310-1311 n.6. Because of understaffing, the lack of supervision, and brutality, four Partlow residents had died. One of the four died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth, and a fourth died from a self-administered overdose of drugs which had been inadequately secured. Dr. Israel Zwerling, Director of the Bronx State Hospital, and an *amicus* witness stated that unintentionally large institutions demoralized their staff. "After 20 years staff people get trapped; some can't even be kind." Expert witness Dr. Donald L. Clopper, Associate Commissioner for Mental Retardation for the Department of Mental Health testified that Partlow was sixty percent overcrowded and that seventy percent of the inmates should never have been committed.

protect their constitutional rights. On March 2, 1972, Johnson issued an emergency order, mandating that the state hire an additional three hundred attendants at Partlow within thirty days. The order also required that Partlow immediately begin a disease immunization program, change their methods of preparing food, and return as many retardates as possible to their parents or guardians as part of the process of normalization.[226] The court stated it was taking such steps in order "to protect the lives and well-being of the residents," because it found Partlow to be a "warehousing institution…wholly incapable of furnishing treatment to the mentally retarded and … conducive only to the deterioration and debilitation of the residents."[227]

During these months of testimony, Governor George Wallace was busy trying to garner additional funds for the institutions. Attending the legislative secessions, he tried to persuade the Legislature to increase its appropriations to the Alabama Mental Health Board by proposing the idea of diverting twenty-four million dollars in the teacher retirement fund to the Department of Mental Health. Several legislators interested in mental health reform argued in support of the measure, but, according to Tinsley Yarbrough's *Frank Johnson and Human Rights in Alabama,* when the Alabama Education Association voiced strong opposition to Wallace's proposal, it was overwhelmingly defeated.[228] After the defeat, Dean reacted in three ways. He mailed each legislator a letter and a picture of a young girl at Partlow sitting on a bench in a straitjacket with flys on her face, stating that the picture was to run in the newspaper the

[226]Wyatt v. Aderholt, 503 F. 2d, 1305, 1309-1311, n.4. See also "The Constitution v. the snakepit, 256.

[227]Wyatt v. Aderholt, 503 F. 2d, 1305, 1309, n.4.

[228]Tinsley E. Yarbrough, *Frank Johnson and Human Rights in Alabama* (University, Ala.: University of Alabama Press, 1981), 121-122.

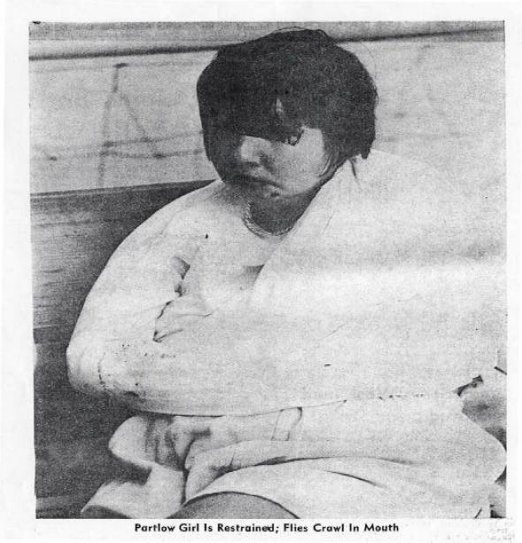

Figure 9. Stan Bailey, "Conditions 'pitiful' at Partlow," *The Alabama Journal*, August 10, 1971.

following day.[229] Dean filed a statement in Johnson's court on March 15, 1972, listing twenty groups that had received from the Legislature more than three million dollars for "unnecessary or non-essential" functions, including livestock shows and beauty pageants. Lastly, Dean filed a motion, original request on September 1, 1971, that the Alabama Mental Health Board be ordered to sell its extensive landholdings, three thousand acres of land near Bryce Hospital. In response to Wallace's earnest attempts to procure funding for the Alabama Mental Health Board, Judge Johnson reserved ruling on Dean's motion. Nevertheless, Dean's actions resulted in Johnson, who had lost patience with the state's repetitive argument of lack of funds, forbidding the state to allocate money for non-essential functions.[230]

[229]Walter Goldman, "The Constitution v. the snakepit: How lawyers are proving that mental inmates have a right to treatment," *New York Times, March 17, 1974*, ProQuest Historical Newspapers, *The New York Times* (1857–2003), p. 256.

[230]Yarbrough, 165–166.

Minimum Moral Standards

The past evidence at the formal hearings established the fact that the three mental health institutions did not provide adequate medical treatment or an adequate staff for its patients. On April 13, 1972, Judge Johnson, unconvinced by the state's argument of inadequate funds, issued two rulings: a comprehensive order for Bryce and Searcy Hospitals containing thirty-five standards and a similar order for Partlow, containing forty-nine "Minimum Constitutional Standards for Adequate Habilitation of the Mentally Retarded." Stickney's "Philosophy and Goals of a Mental Health Department," and the guidelines that the defendants, Drs. Stickney and Folsom had proposed in their earlier report, were the references Johnson used for his decrees of mental health standards. Johnson also incorporated the conditions that the plaintiffs and *amicus curiae* had stipulated as mandatory for a constitutionally acceptable minimum treatment program.

The minimum constitutional standard decree for Bryce/Searcy set forth specific standards guaranteeing basic patient rights to privacy and dignity. The standards granted the inmates the freedom from unnecessary medication or restraint, freedom from experimentation and hazardous treatments, such as lobotomy, electroconvulsive treatment, and adverse reinforcement conditioning. The court addressed the patient's nutritional needs and the staff-to-patient ratios. The decree stated that the patients had the right to communicate with outsiders, including unrestricted visitation with attorneys, with private physicians, and with other health professionals. The court stated that the hospitals were to compensate a patient for his/her labor. Furthermore, the court ordered the administration to develop individual treatment plans that described the criteria for the patient's release to less restrictive treatment conditions and/or discharge. Johnson

finalized the standards with the requirement that the treatment plans had to be periodically reviewed by the court. The overall issue of the decree was the court's decision to order the residential hospitals to provide the least restrictive conditions necessary to achieve the purposes of commitment, or, in other words, if the hospital could not provide the mandated treatment, then it was to release the patient. [231]

Beyond the Bryce/Searcy requirements, the decree for Partlow set forth standards guaranteeing retarded persons basic rights to adequate habilitation, defined as "the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency."[232] The standards addressed individualized habilitation plans; the humane physical and psychological environment including dignity, privacy, and humane care; and the need for sufficient qualified staff to provide for adequate habilitation. The court also ordered the defendants to prepare and file reports within six months of the orders on the implementation of the standards, and to establish human rights committees to the institutions to review all research and treatment programs in order "to ensure that the dignity and human rights of the residents are preserved." The court declared that neither failure to comply with the decree nor default could be justified by lack or unavailability of operating funds, staff, or facilities. [233]

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[231]Wyatt v. Stickney, 334 F. Supp. 373, 377, 379-386 (1972).

[232]Wyatt v. Stickney, 334 F. Supp. 387 (1972).

[233]Wyatt v. Stickney, 334 F. Supp., 387, 392-407. See also Wyatt v. Aderholt, 503 F. 2d 1305, 1309.

Johnson's Decree Appealed by the Governor

Unhappy with Johnson's decree, Governor Wallace and the Alabama Mental Health Board filed separate notices of appeal to the New Orleans' Fifth Circuit on May 12, 1972. They both argued that Johnson's Federal court lacked the authority to instruct Alabama how to allocate its resources. Wallace advanced six major contentions against Johnson's constitutional minimum standards. The contentions were:

> the district court erred in holding that civilly committed mental patients have a constitutional right to treatment; the court lacked jurisdiction because the suit was in effect a suit against the state proscribed by the Eleventh Amendment; the case involved rights and duties not susceptible to determination by judicially standards; the order of the district court invaded a province of decision-making exclusively reserved to the state legislature; the plaintiffs were not entitled to equitable relief because they had adequate remedies at law to protect the rights they asserted; and finally, the district court erred in awarding plaintiffs' reasonable attorneys' fee.[234]

Wallace asserted that the federal court's recognition of the constitutional right to treatment should lie in the fact that the mentally disabled patient was incapable of being independent. Thus, the primary function of civil commitment was to relieve the burden imposed upon the real victims, the families of the disabled.[235] Wallace concluded in his brief that if the "need for care is justification for commitment, then custodial care is constitutionally adequate to justify continued confinement. The providing of custodial care alone is a tremendously important consideration to patients, their families, and the public-at-large."[236]

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[234]Wyatt v. Aderholt, 503 F. 2d 1307.

[235]Wyatt v. Aderholt, 503 F. 2d 1312

[236]Wyatt v. Aderholt, 503 F. 2d 1312-13, The defendants for Johnson's ruling argued that if the Fifth Circuit recognized a constitutional right to treatment enforceable by federal court, then Johnson's constitutional standards did ensure adequate treatment.

On November 8, 1974, the United States Circuit Court of Appeals in New Orleans issued its opinion. The three judge appellate panel, consisting of John Minor Wisdom, former Mississippi Gov. James P. Colman, and Griffin Bell viewed the issue as being "whether federal district courts have the power to order state mental institutions to provide minimum levels of psychiatric care and treatment to persons civilly committed to the institutions."[237] The Fifth Circuit ruled in favor of Johnson's standards. Neither Wallace nor the Alabama Mental Health Board appealed the Fifth Circuit's ruling.[238] Hence, Judge Johnson's minimum standards became the national guidelines for both medical and legal professionals when dealing with mental health issues.

Three Alabamians: Johnson, Stickney, and Wallace

At the forefront of the litigation were three Alabamians who had brought the abuse to its mental health patients to a closure. Religious teachings, parental guidance, and community needs were the decisive factors that had structured their individual character; consequently, the men were different, and yet, they were not so different. Defined by the traditional concept of Southern dignity and its application to humanity, their ingrained values were a basic element of their heritage. As shown by their social, legal, and political actions, this concept of dignity exemplified the continuity of Southern ideologies and values in relationship to respect and honor to humanity. Johnson

[237]Wyatt v. Aderholt, 503 F. 2d 1305-1306.

[238]Committee on the Office of Attorney General, "The Right to Treatment in Mental Health Law" (Raleigh, North Carolina: National Association of Attorneys General, 1976), i. One potential right to treatment case reached the United States Supreme Court in 1975. The Court decided *O'Connor v. Donaldson* not on right to treatment grounds, but on a theory of right to liberty. The Court held that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members and friends."

formulated his federal rulings to fight Alabama's social and political networks that perpetuated the segregated cast system. Stickney, by instigating the landmark *Wyatt* ruling, initiated a radical overview of the methodology of medical treatment for mentally disabled patients throughout the United States. In addition, as a defendant in the *Wyatt* case, Stickney became a nationally respected authority on community mental health issues. Not to be outdone by the other two, Wallace, by crying "wolf" over federal intervention into state rights, guaranteed federal control of the litigation and shifted Alabama's moral, political, and financial responsibilities over to Washington, D.C.

CONCLUSION

MINIMUM STANDARDS AND MINIMUM MORAL RIGHTS

Introduction

As Alabama's mental health administration expanded to include three residential hospitals, ten thousand acres of land, and a budget of twenty-four million dollars, Peter Bryce's original rhetoric of the virtues of moral treatment and occupational therapy continued to shape the institutions' approaches to treating mental illness. It also operated without sufficient funds, sufficient staff, or sufficient moral treatment; consequently, for generations, it abused its citizens. Equally disturbing, communities throughout the state continued to stigmatize the inmates as inferior, both intellectually and socially. Society felt that people got what they deserved for being what they were, into a certain class or as a certain color. While having to endure social exclusion, the indigents, mostly farmers and sharecroppers, were vulnerable for social neglect and prime candidates for admission into the asylums. Alabama was a society that allowed the issues of class and color to supersede human rights.

The indigents were also denied protection of the law for the state's legal system did not decree fair guidelines for involuntary commitment procedures. It facilitated easy access for society to place the poor, the uneducated, the misfits, and the undesirables in asylums. Once admitted, many become residential peons without legal rights. Another

salient aspect of the system was the way in which the racial ramifications of discriminatory state and federal laws allowed for the institutionalized neglect of black citizens in segregated environments, the denial of basic rights such as equal treatment, staff, and funding. Nor were the "feebleminded," whether white or black, provided with or protected by their constitutional rights.

Another factor working against the interests of patients was the Alabama Legislature. The political body influenced the living standards for the poor. During periods when laissez-faire policies and social Darwinism characterized the national political culture, Alabama's Legislature wrote state constitutions that set into motion the disfranchisement of poor white and African-American tenant farmers and sharecroppers. As the years passed, the state's legislative enactments continued to lack progressive policies for the mental disabled, and lawmakers fell far short in their obligation to protect Alabama's citizens and guarantee their civil and human rights. Furthermore, the state refused to shoulder the fiscal burden of providing for the destitute by the removal of social welfare programs and the appropriation of funds for the mentally disabled. By consciously failing to allocate adequate monies for the operation of the mental health institutions, the state was negligent in its duty to the asylums and in its duty as protector of the human rights of the mentally ill.

Fortunately, in 1974, the legal and administrative changes at the three institutions were in-place because of the *Wyatt* ruling and the follow-up hearings. The Department of Mental Health cut the number of patients at the three institutions by fifty percent, while the annual budget for the patients more than double, lifting Alabama from the bottom on

the national list for the per-capita expenditures for mentally disabled citizens.[239] Nevertheless, the Department of Mental Health did not comply with the minimum standards for several reasons. First, it failed in acquiring the required number of professionals needed in order to meet the new patient/physician ratio. Second, it lacked the funds to upgrade the hospital facilities. Third, it was without funds to provide adequate treatment, resulting in the court releasing over half of the hospitals' patients. Finally, many of the hospitals' employees refused to follow the minimum standard guidelines when assisting the patients.

The Long Road to Redemption

The Department of Mental Health was unable to comply with the standards. With the inability to attract sufficient numbers of professionals required to meet the new patient/physician ratio and the exorbitant expense of upgrading the hospital facilities and the patients' treatment procedures, the court released over half of the hospitals' patients by 1975. Adding to the Department's numerous problems was the fact that many of the hospitals' employees did not follow the Wyatt standards when treating the patients. In June 1977, due to information received from the in-house human rights committees and newspaperman Paul Davis concerning physical abuse to Partlow's patients by the employees, Johnson placed the Department of Mental Health under court rule.

On January 15, 1980, the Middle District court placed the newly named Department of Mental Health and Mental Retardation in receivership under Governor

[239]Walter Goldman, "The Constitution v. the snakepit: How lawyers are proving that mental inmates have a right to treatment," *New York Times*, March 17, 1974 , ProQuest Historical Newspapers, *The New York Times* (1857–2003), 256.

Fob James. Although failing to comply with the standards under James' watch, the Department did make some progress. During the following years, Alabama constructed smaller and code-compliant community centers that reduced the overcrowding at the three hospitals and paved the way for massive deinstitutionalization. In 1986, the Department entered into a new consent decree with the plaintiffs. The decree required all facilities to achieve Joint Commission for the Accreditation of Hospitals (JCAH) accreditation and Title XIX certification. It focused on the guidelines of the Wyatt Standards, calling for the development of quality care, an internal advocacy system, and the placement of patients in unrestrictive community centers. The decree also replaced the Court Monitor with the Wyatt Consultant Committee, consisting of four outside experts and the Director of Internal Advocacy, Kathy Sawyer whose mission was to advise the Department on ways to achieve compliance.

Although the Department had worked diligently with the plaintiffs to secure compliance, District Court Judge Myron Thompson ruled in 1995 that the state still lacked compliance with approximately thirty percent of the Wyatt standards. Nevertheless, Thompson did release several mental health centers from supervision. Over the nest three years, the Department made significant progress in developing community services, a supporting infrastructure, and an internal advocacy program. In 1999, the court dissolved the 1986 consent decree and approved a new settlement agreement, allotting the Department three years to implement the agreement's specific requirements. On October 1, 2000, Department of Mental Health Commissioner Kathy Sawyer, following the court's wishes, established twelve work groups to develop compliance plans in areas such as quality improvement, internal advocacy, community education,

census reduction, and community expansion. Sawyer also incorporated the Wyatt Standards into the Department's policy and procedure manual and required all facilities to implement and adhere to the policies. An evaluation ordered by the court concluded that the efforts of the state under the leadership of Sawyer, accompanied with the consistent support of Governors Donald Seligman and Bob Riley and the state Legislature had resulted in a significant transformation of the attitude and performance of the Department. On December 5, 2003, Judge Thompson held a fairness hearing to consider a joint motion of compliance with the 1999 settlement agreement. Satisfied with the Department's performance that ensured the constitutional right of civilly committed mental patients to receive adequate treatment, Thompson terminated the lawsuit. In attendance in the courtroom was forty-nine-year-old Rickey Wyatt.

Costing the state over 15 million dollars in litigation fees, the *Wyatt v. Stickney* case ended after spanning thirty-three years of social transformations, litigations, and political adjustments. Ending the longest running mental health lawsuit in the nation was Judge Myron Thompson, an African-American; with the Mental Health Commissioner Katherine Sawyer, a female African-American; and Republican Governor Bob Riley in the audience. During those years, Judge Johnson's constitutional minimum standards for patient care were widely implemented throughout Alabama and the nation's mental health system, setting standards of care that have improved the lives of countless mentally disabled persons. In 1970, there were ten thousand residents in mental illness facilities and two thousand residents in mental retardation facilities, with fewer than fifteen thousand persons receiving community-base services. By 2005, over one hundred thousand citizens, both mental ill or mental retarded, received care in community-based

facilities, fewer than fifteen hundred resided in state institutions, and state funding exceeded over five hundred million dollars.[240] In many ways, Alabama had illustrated successful reform with increased attention to community mental health services, improved institutional care with appropriate staffing, limited inappropriate "dumping" of mentally challenge citizens, all mental health hospitals were JCAH certified, and major improvements in civil commitment procedures.[241]

Conclusion

Over the decades, thousands of people were institutionalized, a tragedy rationalized with rhetoric justifying those actions. The *Wyatt* case brought to the national forefront the rhetoric that disguised the abuses committed to the mentally disabled. Generations of immoral treatment subsided with Judge Johnson's sets of minimum constitutional standards based on Stickney's guidelines. These standards became the federal guidelines and the major precedent for mental disability civil rights cases.[242]

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[240]"33-year-old Alabama lawsuit filed against mental health system ends," *The Decatur Daily News*, 6 December 2003. U.S. District Judge Myron Thompson, who inherited the case from Johnson, dismissed the case at the request of attorneys for both the state and mental patients. Thompson agreed with attorneys from both sides who said the state had meet the requirements need in order to close the case. Several advocacy groups, including ARC and the National Alliance for the Mentally Ill endorsed terminating the case. Rickey Wyatt, now forty and disabled by arthritis, is living near Tuscaloosa. Most of the original players, such as Judge Johnson, Dr. Stickney, and Governor George Wallace, have passed away. See also, Department of Mental Health and Mental Retardation, "Historic Wyatt Case Ends," *Central Office Outlook* (DMH/MR: Montgomery, Alabama, 2004), 2.

[241]"Thompson Approves Wyatt Settlement Agreement" Department of Mental Health/Mental Retardation, available from http://www.mh.state.al.us/admin/downloads/PR_0005_CommissionerPTSD_Ozark.htm., Internet; accessed 13 March 2005. "The *Wyatt* case created mental health law," said Ira Burnim, legal director for the Bazelon Center for Mental Health Law in Washington, D.C. and counsel for the plaintiffs since 1981. "It forged the tool to end horrible abuses in state institutions and provided the spark for three decades of civil rights advocacy on everything from equal access to public education to fair housing in the community."

[242]"The Fourteenth Amendment of the United States Constitution," The Declaration of Independence and The Constitution of the United States: with an Introduction by Pauline Maier, (New

The *Wyatt* case was also instrumental in facilitating the partnership of the Department of Justice, the American Psychiatric Association, and the American Psychological Association as *amicus,* which promoted the interdisciplinary alliance of lawyers and doctors. From this alliance came the development of the Commission on the Rights of the Mentally Disabled by the American Bar Association that assists attorneys in attacking and gaining favorable decisions concerning mental health abuse. For generations, mental health cases have gone unattended, but now, paramount issues, such as the indefinite confinement of a mentally retarded person who had been found incompetent to stand trial was in violation of his right to due process, an involuntarily committed patient who was not granted treatment could sue for damages from the institution, an institutionalized patient's "consent' to experimental brain surgery was not legally valid, sterilization operations could not be performed on inmates of a mental institution unless they were safeguarded by constitutional protection, patient-workers at institutions for the mentally handicapped were entitled to compensation under provisions of the minimum wage law, and retarded children had a right to free public education just like other children are addressed and resolved.[243] Gone are the times when society was guilty of dismissing the mentally ill and the mentally retarded as "somehow less human"

York: Bantam Books, 1998), 83. Section 1. Committee on the Office of Attorney General, "The Right to Treatment in Mental Health Law," (Raleigh, North Carolina: National Association of Attorneys General, 1976), i. See also, Frost, 31-32. Frost argues that mental health law continues to be one of the most rapidly developing areas of public law. According to the authors in order to make sense of this is to focus on the three interwoven threads that give this area of law its distinctive color and character: equality of citizenship, liberty, and entitlement. Stickney, 15.

[243]Goldman, "The Constitution v. the snakepit," 256.

and that "by hiding them away, attempting to break the connection between us, we deny their humanity and reject our own."[244]

[244]Goldman, "The Constitution v. the snakepit," 256. "UA could take over mental hospital land," *Decatur Daily News*, available from http://www.decaturdaily.com/decaturdaily/news/060117/land.shtm.; internet, accessed 1 November 2006. By late 2006, a little over three hundred people received treatment in the renovated buildings at Bryce Hospital. The original buildings, listed on the National Register of Historic Places, sit empty on two hundred acres adjacent to the University of Alabama. Although the University of Alabama, landlocked and having built on most of the Hospital's surrounding land, desires the land on which the Hospital is located, it is aware that it would be costly to repair the original buildings and to destroy the newer surrounding buildings; consequently, the fate of the asylum remains unknown.

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APPENDIX

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE HABILITATION OF THE MENTALLY RETARDED

I. *Definitions*:

The terms used herein below are defined as follows:

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

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

c. "Qualified Mental Retardation Professional"—

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

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

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

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

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

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

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

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

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

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

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

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

II. *Adequate Habilitation of Residents*

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.
2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.
3. a. No person shall be admitted to the institution unless a prior determination shall have been made that residence in the institution is the least restrictive habilitation setting feasible for that person.

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

   c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.
4. No borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.
5. Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps.
   a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, *supra*, and the other standards proposed herein.
   b. School-age residents shall be provided a full and suitable educational program. Such educational program standards:

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

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

III. *Individualized Habilitation Plans*

7. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialist to determine if admission is appropriate.
   a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.
   b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.

8. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.
9. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible but no later than 14 days [of] institution. An interim program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, *supra*, shall commence promptly upon the resident's admission. Each individualized habilitation plan shall contain:
    a. a statement of the nature of the specific limitations and specific needs of the resident;
    b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;
    c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;
    d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;
    e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;
    f. the criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected data for discharge.
10. As a part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.
11. One Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is release when appropriate to a less restrictive habilitation setting.
12. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an interdisciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care workers as are directly involved in his habilitation and care.
13. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis. In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation for mental retardation with his medical treatment.
14. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals who are directly involved with the particular resident. All information contained in a resident's records shall e considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:
    a. identification data, including the resident's legal status;
    b. the resident's history, including but not limited to:
    c. the resident's grievances if any;
    d. an inventory of the resident's life skills;
    e. a record of each physical examination which describes the results of the examination;

f. a copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;
g. the findings made in periodic reviews of the habilitation plan (see Standard 12, *supra*), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary;
h. a copy of the post-institutionalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan'
i. a medication history and status, pursuant to Standard 22, *infra*;
j. a summary of each significant contact by a Qualified Mental Retardation Professional with the resident;
k. a summary of the resident's response to his program prepared by a Qualified Mental Retardation Professional involved in the resident's habilitation and recorded at least monthly. Such response, wherever possible, shall be scientifically documented.
l. a monthly summary of the extent and nature of the resident's work activities described in the Standard 33 (b), *infra* and the effect of such activity upon the resident's progress along the habilitation plan;
m. a signed order by a Qualified Mental Retardation Professional for any physical restraints as provided in Standard 26 (a) (1). *infra*;
n. a description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of resident mistreatment, as required by Standard 28, *infra*;
o. a summary of family visits and contacts;
p. a summary of attendance and leaves from the institution;
q. a record of any seizures, illnesses, treatments thereof, and immunizations.

IV. *Humane Physical and Psychological Environment*

15. Residents shall have a right to dignity, privacy and humane care.
16. Residents shall lose none of the rights enjoyed by citizens of Alabama and of the United States solely by reason of their admission or commitment to the institution, except as expressly determined by an appropriate court.
17. No person shall be presumed mentally incompetent solely by reason of his admission or commitment to the institution.
18. The opportunity for religious worship shall be accorded to each resident who desires such worship. Provisions for religious worship shall be made available to all residents on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.
19. Residents shall have the same rights to telephone communication as patients at Alabama public hospitals, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (See Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually in any restrictions are to be continued.
20. Residents shall be entitled to send and receive sealed mail. Moreover, it shall be the duty of the institution to facilitate the exercise of this right by furnishing the necessary materials and assistance.
21. The institution shall provide, under appropriate supervision, suitable opportunities fore the resident's interaction with members of the opposite sex, except where a Qualified Mental Retardation Professional responsible for the formulation of a particular resident's habilitation plan writes an order to the contrary and explains the reasons therefore.
22. *Medication*:
    a. No medication shall be administered unless at the written order of a physician.
    b. Notation of each individual's medication shall be kept in his medical records (Standard 14 (1) *supra*). At least weekly the attending physician shall review the

drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days.

c. Residents shall have a right to be free from unnecessary or excessive medication. The resident's records shall state the effects of psychoactive medication on the resident. When dosages of such are changed or other psychoactive medications are prescribed, a notation shall be made in the resident's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

d. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation program, or in quantities that interfere with the resident's habilitation program.

e. Pharmacy services at the institution shall be directed by a professionally competent pharmacist licensed to practice in the State of Alabama. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education. Appropriate officials of the institution, at their option, may hire such a pharmacist or pharmacists fulltime or, in lieu thereof, contract with outside pharmacists.

f. Whether employed fulltime or on a contract basis, the pharmacist shall perform duties which include but are not limited to the following:

    1. Receiving the original, or direct copy, of the physician's drug treatment order;
    2. Reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications and advising the physician of any recommended changes, with reasons and with an alternate drug regime;
    3. Maintaining for each resident an individual record of all medications (prescription and non prescription) dispensed, including quantities and frequency of refills;
    4. Participating, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs.

g. Only appropriately trained staff shall be allowed to administer drugs.

23. Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and direct professional supervision as a technique in behavior-shaping programs.
24. Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.
25. Electric shock devices shall be considered a research technique for the purpose of these standards. Such devices shall only be used in extraordinary circumstances to prevent self-mutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed. The use of such devices shall be subject to the conditions prescribed in Standard 24, *supra*, and Standard 29, *infra*, and shall be used only under the direct and specific order of the superintendent.
26. Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to prevent injury to others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose.

    a. Only Qualified Mental Retardation Professionals may authorize the use of restraints.

        4. Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours.

5. A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept.
6. Mechanical restraints shall be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort.
7. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.
8. Daily reports shall be made to the superintendent by those Qualified Mental Retardation Professionals ordering the use of the restraints, summarizing all such uses of restraint, the types used, the duration, and the reasons therefore.

b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.

27. Corporal punishment shall not be permitted.
28. The institution shall prohibit mistreatment, neglect or abuse in any form of any resident.
    a. Alleged violations shall be reported immediately to the superintendent and there shall be a written record that:
        1. Each alleged violation has been thoroughly investigated and findings stated;
        2. The results of such investigation are reported to the superintendent and to the commissioner within 24 hours of the report of the incident. Such reports shall also be made to the institution's Human Rights Committee monthly and to the Alabama Board of Mental Health at its next scheduled public meeting.
    b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.
29. Residents shall have a right not to be subjected to experimental research without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the institution's Human Rights Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.
30. Residents shall have a right not to be subjected to any unusual or hazardous treatment procedures without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and legal counsel. Such proposed procedures shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought.
31. Residents shall have a right to regular physical exercise several times a week. It shall be the duty of the institution to provide both indoor and outdoor facilities and equipment for such exercise.
32. Residents shall have a right to be outdoors daily in the absence of contrary medical considerations.
33. The following rules shall govern resident labor:
    a. *Institution Maintenance*
        1. No resident shall be requir3ed to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered

by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. §206 as amended, 1966.

2. No resident shall be involved in the care (feeding, clothing, bathing), training, or supervision of other residents unless he:
    a. has volunteered;
    b. has been specifically trained in the necessary skills;
    c. has the humane judgment required for such activities;
    d. is adequately supervised; and
    e. is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. §206 as amended, 1966.

b. *Training Tasks and Labor*

1. Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is:
    a. An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;
    b. Supervised by a staff member to oversee the habilitation aspects of the activity.
2. Residents may voluntarily engage in facilitative labor at non-program hours for which the institution would otherwise have to pay an employee, provided the specific labor or any change in labor is:
    a. An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;
    b. Supervised by a staff member to oversee the habilitation aspects of the activity; and
    c. Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. §206 as amended, 1966.
3. Personal Housekeeping. Residents may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.
    a. Payment to residents pursuant to this paragraph shall not be applied to the costs of institutionalization.
    b. Staffing shall be sufficient so that the institution is not dependent upon the use of residents or volunteers for the care, maintenance or habilitation of other residents or for income-producing services. The institution shall formulate a written policy to protect the residents from exploitation when they are engaged in productive work.

34. A nourishing, well-balance diet shall be provided each resident.

a. The diet for residents shall provide at a minimum the Recommended Daily Dietary Allowance as developed by the National Academy of Sciences. Menus shall be satisfying and shall provide the Recommended Daily Dietary Allowances. In developing such menus, the institution shall utilize the Moderate Cost Food Plan of the United States Department of Agriculture. The institution shall not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Moderate Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of residents, discounted for any savings which might result from institutional procurement of such food.

b. Provision shall be made for special therapeutic diets and for substitutes at the request of the resident, or his guardian or nest of kin, in accordance with the religious requirements of any resident's faith.
c. Denial of a nutritionally adequate diet shall not be used as punishment.
d. Residents, except for the non-mobile, shall eat or be fed in dining rooms.

35. Each resident shall have an adequate allowance of neat, clean, suitably fitting and seasonable clothing.

e. Each resident shall have his own clothing, which is properly and inconspicuously marked with his name, and he shall be kept dressed in this clothing. The institution has an obligation to supply an adequate allowance of clothing to any residents who do not have suitable clothing of their own. Residents shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the resident's throughout his stay in the institution.
f. Clothing both in amount and type shall make it possible for residents to go out of doors in inclement weather, to go for trips or visits appropriately dressed, and to make a normal appearance in the community
g. No ambulatory residents shall be dressed daily in their own clothing, including shows, unless contraindicated in written medical orders.
h. Washable clothing shall be designed for multiply handicapped residents being trained in self-help skills, in accordance with individual needs
i. Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training.
j. A current inventory shall be kept of each resident's personal land clothing items.
k. The institution shall make provision for the adequate and regular laundering of the residents' clothing.

36. Each resident shall have the right to keep and use his own personal possessions except insofar as such clothes or personal possessions may be determined to be dangerous, either to himself or to others, by a Qualified Mental Retardation Professional.

37. Each resident shall be assisted in learning normal grooming practices with individual toilet articles, including soap and toothpaste, that are available to each resident:

a. Teeth shall be brushed daily with an effective dentifrice. Individual brushes shall be properly marked , used, and stored;
b. Each resident shall have a shower or tub bath, at least daily, unless medically contraindicated
c. Residents shall be regularly scheduled for hair cutting and styling, in an individualized manner, by trained personnel.
d. For residents who require such assistance, cutting of toe nails and fingernails shall be scheduled at regular intervals.

38. Physical Facilities. A resident has a right to a humane physical environment within the institutional facilities. These facilities shall be designed to make a positive contribution to the efficient attainment of the habilitation goals of the institution.

a. *Resident Unit*. All ambulatory residents shall sleep in single rooms or in multi-resident rooms of no more than six persons. The number of nonambulatory residents in a multi-resident room shall not be allocated a minimum of 80 square feet of floor space per resident in a multi-resident room. Screens or curtains shall be provided to ensure privacy. Single rooms shall have a minimum of 100 square feet of floor space. Each resident shall be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, and appropriate furniture such as a chair and a bedside table, unless contraindicated by a Qualified Mental Retardation Professional who shall state the reasons for any such restriction.
b. *Toilets and Lavatories.* There shall be one toilet and one lavatory for each six residents. A lavatory shall be provided with each toilet facility. The toilets shall be installed in separate stalls for ambulatory residents, or in curtained areas for non-ambulatory residents, to ensure privacy, shall be clean and free of odor, and shall be equipped with appropriate safety devices for the physically handicapped. Soap and

towels and/or drying mechanisms shall be available in each lavatory. Toilet paper shall be available in each toilet facility.

c. *Showers.* There shall be one tub or shower for each eight residents. If a central bathing area is provided, each tub or shower shall be divided by curtains to ensure privacy. Showers and tubs shall be equipped with adequate safety accessories,

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

e. *Dining Facilities*. The minimum dining room area shall be ten square feet per resident. The dining room shall be separate from the kitchen and shall be furnished with comfortable chairs and tables with hard, washable surfaces.

f. *Linen Servicing and Handing*. The institution shall provide adequate facilities and equipment for the expeditious handling of clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, but in any event no less than every seven days, to assure sanitation and resident comfort. After soiling by an incontinent resident, bedding and linen must be immediately changed and removed from the living unit. Soiled linen and laundry shall be removed from the living unit daily.

g. *Housekeeping*. Regular housekeeping and maintenance procedures which will ensure that the institution is maintained in a safe, clean, and attractive condition shall be developed and implemented.

h. *Non-ambulatory residents*. There must be special facilities for non-ambulatory residents to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit non-ambulatory residents to communicate their needs to staff.

i. *Physical Plant*.

    1. Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation so as to ensure the health, comfort, safety and well-being of the residents and so as not to impede in any manner the habilitation programs of the residents.
    2. Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of residents at all times. Ventilation systems shall be adequate to remove steam and offensive odors or to mask such odors. The temperature in the institution shall not exceed 83F nor fall below 68F.
    3. Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for resident use (110F at the fixture) and for mechanical dishwashing and laundry use (180F at the equipment). Thermostatically controlled hot water valves shall be equipped with a double valve system that provides both auditory and visual signals of valve failures.
    4. Adequate refuse facilities shall be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.
    5. The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the institution shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to it.

V. Qualified Staff in Numbers Sufficient to provide Adequate Habilitation

34. Each Qualified Mental Retardation Professional and each physician shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama.
    a. All resident care workers who have not had prior clinical experience in a mental retardation institution shall have suitable orientation training.
    b. Staff members on all levels shall have suitable, regularly scheduled in-service training.
35. Each resident care worker shall be under the direct professional supervision of a Qualified Mental Retardation Professional.
36. Staffing Ratios
    a. Qualified staff in numbers sufficient to administer adequate habilitation shall be provided. Such staffing shall include but not be limited to the following fulltime professional and special services. Qualified Mental Retardation Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Substantial changes in staff deployment may be made with the prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure would enhance the habilitation of the residents. Professional staff shall posses the qualifications of Qualified Mental Retardation Professionals as defined herein unless expressly state otherwise.

	Mild	Moderate	Severe/ Profound
b. Unit	60	60	60
1. Psychologists	1:60	1:60	1:60
2. Social Workers	1:60	1:60	1:60
3. Special Educators (shall include an equal number of master's degree and bachelor's degree holders in special education)	1:15	1:10	1:30
4. Vocational Therapists	1:60	1:60	——
5. Recreational Therapists (shall be master's)	1:60	1:60	1:60
6. Occupational Therapists	——	——	1:60
7. Registered Nurses	1:60	1:60	1:12
8. Resident Care Workers	1:2.5	1:1.25	1:10

The following professional staff shall be fulltime employees of the institution who shall not be assigned to a single unit but who shall be available to meet the needs of any resident of the institution:

Physicians	1:200
Physical Therapists	1:100
Speech & Hearing therapists	1:100
Dentists	1:200
Social Workers (shall be principally involved in the placement of residents in the community and shall include bachelor's degree graduates from an accredited program in social work)	1:80
Chaplains	1:200

    c. Qualified medical specialists of recognized professional ability shall be available for specialized care and consultation. Such specialist services shall include a psychiatrist on a on-day per week basis, a physiatrist on a two-day per week basis, and any other medical or health-related specialty available in the community

VI. *Miscellaneous*

37. The guardian or next of kin of each resident shall promptly, upon resident's admission, receive a written copy of all the above standards for adequate habilitation. Each resident, if the resident is able to comprehend, shall promptly upon his admission be orally informed in clear language of the above standards and, where appropriate, be provided with a written copy.
38. The superintendent shall report in writing to the next of kin or guardian of the resident at least every six months on the resident's educational, vocational and living skills progress and medical condition. Such report shall also state any appropriate habilitation program which has not been afforded to the resident because of inadequate habilitation resources.
39. a. No resident shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without prior certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures.
    b. No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional convenience.
40. No resident shall have any of his organs removed for the purpose of transplantation without compliance with the procedures set forth in Standard 30, *supra*, and after a court hearing on such transplantation in which the resident is represented by a guardian *ad litem*. This standard shall apply to any other surgical procedure which is undertaken for reasons other than therapeutic benefit to the resident.
41. Within 90 days of the date of this order, each resident of the institution shall be evaluated as to his mental, emotional, social, and physical condition. Such evaluation or reevaluation shall be conducted by an interdisciplinary team of Qualified Mental Retardation Professionals who shall use professionally recognized tests and examination procedures. Each resident's guardian, next of kin or legal representative shall be contacted and his readiness to make provisions for the resident's care in the community shall be ascertained. Each resident shall be returned to his family, if adequately habilitated, or assigned to the least restrictive habilitation setting.
42. Each resident discharged to the community shall have a program of transitional habilitation assistance.
43. The institution shall continue to suspend any new admissions of residents until all of the above standards of adequate habilitation have been met.
44. No person shall be admitted to any publicly supported residential institution meets the above standards.

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE

TREATMENT OF THE MENTALLY ILL

I. *Definitions:*

a. "Hospital" Bryce and Searcy Hospitals.

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

c. "Qualified Mental Health Professional"

i. a psychiatrist with three years of residency training in psychiatry;

ii. a psychologist with a doctoral degree from an accredited program;

iii. a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;

iv. a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.

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

II. *Humane Psychological and Physical Environment*

1. Patients have a right to privacy and dignity.

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

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

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

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

6. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The superintendent of the hospital and the attending physician shall be responsible for

all medication given or administered to a patient. The use of medication shall not exceed standards of use that are advocated by the United States Food and Drug Administration. Notation of each individual's shall be kept in his medical records. At least weekly the attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

7. Patients have a right to be free from physical restraint and isolation. Except for emergency situation, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or place in isolation only on a Qualified Mental Health Professional's written order which explains the rationale for such action. The written order may be entered only after the Qualified Mental Health Professional has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one hour, by which time a Qualified Mental Health Professional shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. While in restraint or isolation the patient must be seen by qualified ward personnel who will chart the patient's physical condition (if it is compromised) and psychiatric condition every hour. The patient must have bathroom privileges every hour and must be bathed every 12 hours.
8. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.
9. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive [adverse] reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.
10. Patients have a right to receive prompt and adequate medical treatment for any physical ailments.
11. Patients have a right to wear their own clothes and to keep and use their own personal possessions except insofar as such clothes or personal possessions may be determined by a Qualified Mental Health Professional to be dangerous or otherwise inappropriate to the treatment regimen.
12. The hospital has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the

opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay in the hospital

13. The hospital shall make provision for the laundering of patient clothing.
14. Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the hospital to provide facilities and equipment for such exercise.
15. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.
16. The right to religious worship shall be accorded to each patient who desires such opportunities. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.
17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.
18. The following rules shall govern patient labor:
    a. *Hospital Maintenance* No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. s 206 as amended, 1966.
    b. *Therapeutic Tasks and Therapeutic Labor*
        (1) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the hospital, provided the specific task or any change in assignment is:
            a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and
            b. Supervised by a staff member to oversee the therapeutic aspects of the activity.
        (2) Patients may voluntarily engage in therapeutic labor for which the hospital would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:
            a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and
            b. Supervised by a staff member ant over see the therapeutic aspects of the activity; and
            c. Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. s 206 as amended, 1966.
    c. *Personal Housekeeping* Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.
    d. Payment to patients pursuant to these paragraphs shall not be applied to the costs of hospitalization.

19. *Physical Facilities*

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

a. *Resident Unit*

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

b. *Toilets and Lavatories*

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

c. *Showers*

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

d. *Day Room*

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

e. *Dining Facilities*

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

f. *Linen Servicing and Handling*

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

g. *Housekeeping*

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

h. *Geriatric and Other Non-ambulatory Mental Patients*

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

i. *Physical Plant*

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

(2). Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of patients at all times and the removal of undesired heat, steam and offensive odors. Such facilities shall ensure that the temperature is the hospital shall not exceed 83 degrees F. nor fall below 68F.

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

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

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

19A. The hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

20. *Nutritional Standards*

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

III. *Qualified Staff in Numbers Sufficient to Administer Adequate Treatment*

21. Each Qualified Mental Health Professional shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama.
22. a. All Non-Professional Staff Members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.
    b. Staff members on all levels shall have regularly scheduled in-service training.
23. Each Non-Professional Staff Member shall be under the direct supervision of a Qualified Mental Health Professional.
24. *Staffing Ratios*

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

Classification	Number of Employees
Unit Director	1
Psychiatrist (3 years' residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN)	12
Licensed Practical Nurses	6
Aide III	6
Aide II	16
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph.D.) (doctoral degree from accredited program)	1
Psychologist (M.A.)	1
Psychologist (B.S.)	2
Social Worker (MSW) (from accredited Program)	2
Patient Activity Therapist (M.S.)	1
Patient Activity Aide	10
Mental Health Technician	10
Dental Hygienist	1
Chaplain	5
Vocational Rehabilitation Counselor	1
Volunteer Services Worker	1

Classification	Number of Employees
Mental Health Field Representative	1
Dietitian	1
Food Service Supervisor	1
Cook II	2
Cook I	3
Food Service Worker	15
Vehicle Driver	1
Housekeeper	10
Messenger	1
Maintenance Repairman	2

III. *Individualized Treatment Plans*

25. Each patient shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the hospital.
26. Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate Qualified Mental Health Professionals, including a psychiatrist, and implemented as soon as possible—in any event no later than five days after the patient's admission. Each individualized treatment plan shall contain:
    a. a statement of the nature of the specific problems and specific needs of the patient;
    b. a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;
    c. a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;
    d. a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;
    e. a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;
    f. criteria for release to less restrictive treatment conditions, and criteria for discharge;
    g. a notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18.
27. As part of his treatment plan, each patient shall have an individualized post-hospitalization plan. This plan shall be developed by a Qualified Mental Health Professional as soon as practicable after the patient's admission to the hospital.
28. In the interests of continuity of care, whenever possible, one Qualified Mental Health Professional (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording the patient's progress. This Qualified Mental Health Professional shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.
29. The treatment plan shall be continuously reviewed by the Qualified Mental Health Professional responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by a Qualified Mental Health Professional other than the professional responsible for supervising the implementation of the plan.

30. In addition to treatment for mental disorders, patients confined at mental disorders, patients confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis. In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.
31. Complete patient records shall be kept on the ward in which the patient is place and shall be available to anyone properly authorized in writing by the patient. These records shall include:
    a. Identification data, including the patient's legal status;
    b. A patient history, including but not limited to:
        (1) family data, educational background, and employment record;
        (2) prior medical history, both physical and mental, including prior hospitalization;
    c. The chief complaints of the patient and the chief complaints of others regarding the patient;
    d. An evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;
    e. A summary of each physical examination which describes the results of the examination;
    f. A copy of the individual treatment plan and any modifications thereto;
    g. A detailed summary of the findings made by the reviewing Qualified Mental Health Professional after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;
    h. A copy of the individualized post-hospitalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;
    i. A medication history and status, which includes the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;
    j. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;
    k. A detailed summary on at least a weekly basis by a Qualified Mental Health Professional involved in the patient's treatment of the patient's progress along the treatment plan;
    l. A weekly summary of the extent and nature of the patient's work activities described in Standard 18, *supra*, and the effect of such activity upon the patient's progress along the treatment plan;
    m. A signed order by a Qualified Mental Health Professional for any restrictions on visitations and communication, as provided in Standards 4 and 5, *supra*;
    n. A signed order by a Qualified Mental Health Professional for any physical restraints and isolation, as provided in Standard 7, *supra*;
    o. A detailed summary of any extraordinary incident in the hospital involving the patient to be entered by a staff member noting that he has personal

knowledge of the incident or specifying his other source of information, and initialed within 24 hours by a Qualified Mental Health Professional;

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

32. In addition to complying with all the other standards herein, a hospital shall make special provisions for the treatment of patients who are children and young adults. These provisions shall include but are not limited to:
    a. Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending Qualified Mental Health Professional, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.
    b. A treatment plan which considers the chronological, maturational, and developmental level of the patient;
    c. Sufficient Qualified Mental Health Professionals, teachers, and staff members with specialized skills in the care and treatment of children and young adults;
    d. Recreation and play opportunities in the open air where possible and appropriate residential facilities;
    e. Arrangements for contact between the hospital and the family of the patient.
33. No later than 15 days after a patient is committed to the hospital, the superintendent of the hospital or his appointed, professionally qualified agent shall examine the committed patient and shall determine whether the patient continues to require hospitalization and whether a treatment plan complying with Standard 26 has been implemented. If the patient no longer requires hospitalization in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.
34. The Mental Health Board and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, out-patient treatment, and treatment in the psychiatric ward of a general hospital.

IV. *Miscellaneous*

35. Each patient and his family, guardian, or next friend shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.