

Rights of People that are Institutionalized under Wyatt v. Stickney

This contains excerpts of the standards recognized in Wyatt V. Stickney for people confined in institutions for people with mental disabilities. The standards were originally established in 1972 and are reported at 344 F. Supp. 373, 379 (M.D. Ala. 1972) (people with mental retardation). Both sets of standards were amended in 1980, and the mental health standards were amended again in 1992. The latter are published in Wyatt by and through Rawlins v. King, 793 F. Supp. 1058, 1071 (M.D. Ala. 1992).

For convenience and clarity, the standards are listed in alphabetical order by subject, not in the order they appear in the court orders. These excerpts omit some definitions and details. Condensed portions are indicated by a summary in brackets.

Aversive Procedures (1980)

No patient shall be subjected to any aversive conditioning or other systematic attempt to alter his behavior by means of painful or noxious stimuli, except under the following conditions:

A. A program of aversive conditioning has been recommended by a Qualified Mental health professional ("QMHP") trained and experienced in the use of aversive conditioning. *This recommendation shall be made in writing with detailed clinical justification and an explanation of which alternative treatments were considered and why they were rejected.* The recommendation must be concurred in by another Qualified Mental health Professional trained and experienced in the use of aversive conditioning and approved by the superintendent or medical director of the facility.

B. *The patient has given his express and informed consent in writing to the administration of aversive conditioning.* It shall be the responsibility of the treating psychiatrist to provide the [patient with complete and accurate information concerning the nature and effects of aversive therapy, to assist the patient in comprehending the significance of such information, and to identify any barriers to such comprehension. The written consent signed by the patient shall include a statement of the nature of the treatment consented to; a description of its purpose, risks, and possible side effects; and a notice to the patient that he has the right to terminate his consent at any time and for any reason.

C. *No aversive conditioning shall be imposed on any patient without the prior approval of the Extraordinary Treatment Committee, ... whose primary responsibility it is to determine, after appropriate inquiry and interview with the patient, whether the patient's consent to such therapy is, in fact, knowing, intelligent, and voluntary and whether the proposed treatment is in the best interest of the patient...*

D. The patient shall be represented throughout all proceedings including the sign of his consent and the deliberations of the Extraordinary Treatment Committee, by legal counsel appointed by the Extraordinary Treatment Committee. *Counsel shall assure, among other things, that all considerations militating against the use of aversive conditioning have been adequately explored and resolved and that the patient is competent to consent to such treatment...*

E. [Written records of consent and approval must be kept.]

F. *Aversive conditioning shall be administered only under the direct supervision of and in the physical presence of a Qualified Mental health Professional trained and experienced in the use of aversive conditioning.*

G. *No patient shall be subjected to an aversive conditioning program which attempts to extinguish or alter socially appropriate behavior or to develop new behavior patterns for the sole or primary purpose of institutional convenience.*

H. *A patient may withdraw his consent or aversive conditioning at any time and for any reason. Such withdrawal of consent may be either oral or written and is to be given effect immediately.*

Seclusion and Restraint

Patients have a right to be free from seclusion and physical restraint. Patients may be placed in seclusion or physically restrained only (a) to prevent a patient from physically injuring himself/herself or others, (b) after alternative treatment interventions have been unsuccessful or after determining that alternative treatment interventions would not be practicable, and (c) when authorized by a written order of a qualified physician who is physically present and has examined the patient. No order for seclusion or restraint may exceed eight hours.

[Exceptions to these rules] may be made in emergency situations when no qualified physician is available. In such situations, the use of restraint or seclusion may be implemented for up to one hour by a trained, clinically privileged, qualified registered nurse to prevent a patient from physically injuring himself/herself or others, after determining that alternative treatment interventions have been unsuccessful or would not be practicable. The nurse must be physically present and evaluate the patient's physical condition to the extent that it is feasible and document the evaluation in the clinical record. A qualified physician should be notified as soon as possible after the emergency episode of seclusion or restraint. A qualified physician should see the patient within four hours of the initiation of seclusion or restraint and preferably within one hour. The emergency episode of seclusion or restraint may be extended up to four hours (i.e., three hours beyond the initial one hour authorized by the qualified registered nurse) upon verbal order of a qualified physician if necessary to prevent a patient from physically injuring himself/herself or others and if, in the opinion of the qualified physician, alternative treatment interventions would be unsuccessful in preventing injury. After the emergency episode has extended for four hours, the patient must be released unless a qualified physician writes a new order for seclusion or restraint that meets the criteria [for seclusion or restraint]. All emergency seclusion or restraint orders (including any related documentation) must be reviewed and signed by a qualified physician within twelve hours of the initial use of seclusion or restraint.

All written orders for seclusion and restraint (including in emergency situations) shall include a clinical assessment of the patient, the alternative treatment interventions attempted, and criteria for the release of the patient which shall relate to the standard for seclusion or restraint...above. When the criteria for release have been met or at the end of the period set out in the order (whichever occurs first), the patient must be released unless the patient is then examined by a qualified physician within twelve hours of the initial use of seclusion or restraint.

A documented observation shall be made of a patient in restraint or seclusion at least every fifteen minutes. The person making the observation shall be made aware of and shall take account of any special medical concerns regarding the patient. The patient must be given bathroom privileges at least every hour, must be bathed at least every twenty-four hours or more frequently if necessary, and must be provided meals and fluids on a regular basis. Vital signs shall be taken as clinically indicated. Patients in restraint shall be released for range of motion exercises as clinically indicated.

Seclusion and restraint shall not be used as punishment or for the convenience of staff or in a manner that causes undue physical discomfort, harm, or pain to the patient. [As needed] orders for seclusion and restraint are prohibited.

Behavior Modification

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. 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.

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 this 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 an in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.

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 above and in accordance with standards on experimentation] and shall be used only under the direct and specific order of the superintendent.

Habilitation Plans

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 after the resident's admission to the institution...Each individualized habilitation plan shall contain:

- (1) A statement of the nature of the specific limitations and specific needs of the resident;
- (2) A description of intermediate and long-range habilitation goals with a projected timetable for their attainment;
- (3) A statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;
- (4) A statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;
- (5) A specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;
- (6) [C]riteria for release to less restrictive settings for habilitation within the institution and, in appropriate cases, movement to less restrictive settings outside the institution, including criteria for discharge and a projected date for discharge.

Least Restrictive Setting

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.

Physical Restraint

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

Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours. 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. 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. 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. Daily reports shall be made to the superintendent by those Qualified

Mental Retardation Professionals ordering the use of restraints summarizing all such uses of restraint, the types used, the duration, and the reasons therefore.

Protection from Harm

The institution shall prohibit mistreatment, neglect or abuse in any form of any resident. 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

Levy, R.M. & Rubenstein, L.S. (1996) *The Rights of People with Mental Disabilities*.
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