THOMAS S CLASS ACTION

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Date(s): Filed early 1980s; Mandates active throughout the 1980s and 1990s; Category dissolved 1998
Location(s): State of North Carolina

1. Summary

The **Thomas S Class Action** represents a foundational piece of litigation in the history of disability rights and mental health policy within the state of North Carolina. Initiated on behalf of a large cohort of institutionalized individuals, the lawsuit focused specifically on residents of state psychiatric facilities who possessed a dual diagnosis: both **cognitive retardation** (intellectual disability) and a serious, recurring or continual **cognitive disease** (mental illness). This population, often marginalized within standard institutional settings that were typically designed to treat either intellectual disability or mental illness, not both concurrently, faced profound deficiencies in specialized care, habilitation, and support services. The central contention of the case was that these individuals were being denied appropriate and necessary services that met their complex needs, often resulting in prolonged institutionalization and a failure to achieve maximum independence or integration into community settings.

The judicial resolution of the **Thomas S Class Action** did not merely result in a monetary settlement; rather, it achieved a comprehensive court order that legally ascertained and mandated specific services and support structures tailored to this uniquely vulnerable group. These mandates required the state to significantly reform its approach to treating the dual-diagnosis population, moving beyond custodial care to embrace active treatment and individualized habilitation planning. This legal intervention was a crucial step in the broader movement toward **deinstitutionalization**, although its specific focus was on defining and protecting the rights of those who often fell through the cracks of existing state systems. The case acknowledged that while many individuals with intellectual disabilities had successfully transitioned to community living following earlier lawsuits, the dual-diagnosis population required specialized administrative and service structures that the state had failed to provide adequately.

Although the special judicial category established by the lawsuit was officially dissolved in 1998, marking the court's satisfaction with the level of state compliance achieved at that time, the legacy of the litigation far exceeded the duration of the court oversight. The case directly prompted a profound structural and organizational change within North Carolina's human services framework. Crucially, it led to the formation of a specialized division dedicated explicitly to delivering **MR/MI services** (Mental Retardation/Mental Illness, now Intellectual Disability/Mental Illness) within the state-led agency responsible for cognitive retardation services. This dedicated administrative structure ensured that the specialized needs of the dual-diagnosis population remained a priority,

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embedding the principles established by the court order into permanent governmental operations, thus continuing to influence policy and funding decades after the formal legal proceedings concluded.

2. Background and Causes

The initiation of the **Thomas S Class Action** must be viewed within the socio-legal context of the late 20th-century deinstitutionalization movement in the United States. Following landmark cases nationally, such as *Wyatt v. Stickney* and *Youngberg v. Romeo*, which established the constitutional right to treatment and habilitation for institutionalized individuals, advocates turned their attention to state systems that lagged in implementing these reforms. North Carolina, like many states, maintained large psychiatric hospitals where individuals with intellectual disabilities were often housed indiscriminately, particularly if their primary diagnosis was compounded by behavioral challenges or concurrent mental illnesses. The systemic failure to distinguish between, or appropriately treat, those with dual diagnoses became the central grievance. Standard state resources were insufficient; psychiatric units were ill-equipped to provide intellectual disability habilitation, and intellectual disability centers often lacked the clinical capacity to manage acute mental illness, leading to cycles of crisis and neglect for the plaintiffs.

A significant contributing factor leading to the lawsuit was the administrative inefficiency and fragmentation of services. Individuals with both intellectual disability and mental illness (often referred to then as MR/MI) were administratively bounced between two separate and often uncommunicative state bureaucracies: one focused on developmental disabilities and the other on mental health. This lack of coordination meant that individualized treatment plans were rarely cohesive, continuity of care was nonexistent, and resources were inappropriately allocated. The plaintiffs argued that the state's failure constituted a violation of their constitutional rights to substantive due process and protection from harm, necessitating judicial intervention to force the creation of a unified, comprehensive, and clinically appropriate system of care. The conditions described in the pleadings painted a picture of warehousing, where the potential for meaningful recovery or community integration was severely hampered by the absence of specialized therapies and staff training tailored to the unique complexities of their combined diagnoses.

Furthermore, the legal advocacy community recognized that while general mandates for community placement were increasing, the dual-diagnosis population often faced unique barriers to successful community integration, including resistance from local service providers who lacked the necessary expertise and funding mechanisms. The cause of action thus arose from the necessity to establish not just a right to services, but a right to a specific, high-quality, specialized type of service delivery system. The goal was to secure a remedy that addressed the structural flaws in North Carolina's delivery system, ensuring that the unique characteristics of this sub-population were recognized and adequately resourced, thereby preventing future systemic failures

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that led to inappropriate institutional placement or regression in functional skills.

3. Key Developments and Mandates

The legal process involved in the **Thomas S Class Action** was protracted, involving extensive discovery, expert testimony, and eventual court-monitored settlement negotiations. A critical early development was the judicial certification of the specific subclass of plaintiffs, legally establishing the unique need of individuals with both cognitive retardation and serious, continual cognitive disease who were residing in state psychiatric hospitals. This certification was crucial because it isolated the population whose needs were most severely neglected by the existing bifurcated system. The court recognized that for this group, the standard remedy of simply transferring them to developmental centers was often inappropriate, and immediate community placement was frequently impossible without substantial, specialized preparation and support structures.

The resulting court order, often referred to as a consent decree or stipulated settlement, imposed detailed remedial mandates upon the State of North Carolina. These mandates were designed to overhaul the service delivery system for the dual-diagnosis population. They included requirements for specific staffing ratios, enhanced training for staff in both psychiatric and intellectual disability methodologies, and the development of specialized assessment tools capable of accurately evaluating the complex needs arising from co-occurring conditions. A cornerstone of the mandate was the establishment of a robust system of **Individual Habilitation Plans (IHPs)**, which were required to be outcome-oriented and focused on measurable progress toward community integration and improved quality of life, emphasizing skills development over mere symptom management.

A third significant development was the creation of a court-appointed monitor or oversight committee, a common feature in public interest class actions, tasked with measuring the state's progress against the stipulated benchmarks. This oversight mechanism provided a crucial accountability layer, ensuring that the state budget and policy decisions reflected a genuine commitment to compliance rather than superficial changes. The mandates dictated strict deadlines for the gradual reduction of the institutional population through the development of appropriate community-based residential and day programs. Furthermore, the court order addressed the necessity of establishing "step-down" services--specialized, intensive residential facilities designed to transition individuals safely from large institutions into smaller, integrated community settings, ensuring clinical stability before full integration.

4. Consequences and Institutional Impact

The most enduring consequence of the **Thomas S Class Action** was the profound and permanent restructuring of North Carolina's bureaucratic infrastructure concerning developmental disabilities.

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Recognizing that ad-hoc efforts would fail to sustain compliance, the state was compelled to create a dedicated administrative entity--a specialized division--to manage services for the dual-diagnosis population. This new organizational unit, focused exclusively on MR/MI services, provided a single point of accountability and expertise, ensuring that funding, planning, and policy development for this complex group were centralized and consistent, overcoming the historical problem of bureaucratic fragmentation. This division became responsible for administering grants, training local providers, and maintaining the fidelity of the specialized care standards established by the court.

The long-term impact on service delivery extended beyond mere administration. The case dramatically improved the quality of care and the expectations surrounding services provided to individuals with co-occurring intellectual disability and mental illness. It established a legal and clinical precedent that recognized the distinct clinical needs of the population, leading to the development of specialized community support teams (CSTs) and mobile crisis units trained explicitly to handle dual-diagnosis individuals. This shift facilitated a move away from relying on emergency room visits or involuntary commitment as primary responses to behavioral crises, replacing them with planned, preventive, and specialized interventions designed to stabilize the individual within their residential setting.

While the specific judicial category established by the lawsuit was dissolved in 1998--a landmark moment signifying that the court found the state had achieved substantial compliance with the core components of the decree--the principles of the case remained foundational. The dissolution did not signal the end of specialized services, but rather the successful embedding of these services into the routine administrative practice of the state. The legal action ultimately functioned as a catalyst, forcing policy makers and budget managers to prioritize a previously invisible and underserved group, creating a legacy of mandated specialized care that continues to shape eligibility requirements, funding streams, and the structure of community-based services across North Carolina, ensuring adherence to the least restrictive environment mandate established nationally by legal precedent.

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5. Legal Context and Precedent

The **Thomas S Class Action** derived much of its legal weight from established precedents regarding the rights of institutionalized persons. Central to the legal argument was the principle, affirmed by the U.S. Supreme Court in cases like *Olmstead v. L.C.* (though decided later, the principles were emerging), that unjustified isolation of individuals with disabilities constitutes discrimination. However, the immediate precursor was the constitutional right to safety and freedom from undue restraint recognized in *Youngberg v. Romeo* (1982), which mandated reasonably non-restrictive confinement conditions and necessary training to ensure safety and liberty. The unique contribution of *Thomas S.* was applying and enforcing these broad rights

specifically to the dual-diagnosis population, demonstrating that "necessary training" and "non-restrictive conditions" required highly specialized administrative and clinical structures that did not yet exist.

The case functioned as a detailed blueprint for how a state must deliver services to meet constitutional minimums when dealing with highly complex needs. It went beyond simply demanding better conditions; it mandated systemic change in staffing, training, and inter-agency cooperation. The long duration of the judicial oversight (1980s through 1998) highlights the deep-seated institutional resistance and the massive scope of the reform required. The settlement established a powerful framework for defining "appropriate treatment" within the context of co-occurring conditions, setting a standard that was later used by advocates in other states facing similar systemic failures regarding the MR/MI population.

Furthermore, the successful dissolution of the case category in 1998 served as a vital example of how class action litigation could successfully transition from judicial coercion to permanent, institutionalized policy. This resolution demonstrated that the state was capable of maintaining compliance without perpetual court mandate, provided the structural reforms--such as the creation of the dedicated MR/MI division--were robust enough to sustain the mandated level of specialized service delivery and inter-agency coordination. The case thus stands as a significant domestic example of successful public interest litigation leading to lasting administrative and budgetary prioritization of a previously neglected vulnerable population.

Further Reading

Class action lawsuit (Wikipedia)
American Psychiatric Association (APA) - Resources on Dual Diagnosis
North Carolina General Assembly - State laws and policies regarding mental health and developmental disabilities services.

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