TITLE VI...

one year after

a survey of desegregation of health and welfare services in the south

United States Commission on Civil Rights
1966

TITLE VI . . .

one year after

a survey of desegregation of health and welfare services in the south

United States Commission on Civil Rights
1966

Members of the Commission

JOHN A. HANNAH, *Chairman*
EUGENE PATTERSON, *Vice Chairman*
FRANKIE M. FREEMAN
ERWIN N. GRISWOLD
REV. THEODORE M. HESBURGH, C.S.C.
ROBERT S. RANKIN

WILLIAM L. TAYLOR, *Staff Director*

CRI 1.2: C49/3

LETTER OF TRANSMITTAL

The United States Commission on Civil Rights
Washington, D.C., February 1966

THE PRESIDENT
THE PRESIDENT OF THE SENATE
THE SPEAKER OF THE HOUSE OF REPRESENTATIVES

Sirs:

The Commission on Civil Rights presents to you this report pursuant to Public Law 85–315, as amended.

This report appraising one year of operation of Title VI of the Civil Rights Act of 1964 as it pertains to health and welfare services in selected communities of the South is limited in scope and depth because we felt it was necessary to conduct an immediate survey of the most overt forms of discrimination the law was designed to remedy. The Commission found situations of serious concern which indicated the need for coordinated and forceful administrative action by Federal officials. It is heartening to note, however, that officials of the agencies covered in the survey have recognized the need for coordination and implementation of the law on the local level and that they are taking corrective action.

While no legislative action is recommended as a result of this report, we urge your consideration of the facts presented and your sympathetic concern for the efforts of Federal administrators in the field.

Respectfully yours,

JOHN A. HANNAH, *Chairman*
EUGENE PATTERSON, *Vice Chairman*
FRANKIE M. FREEMAN
ERWIN N. GRISWOLD
REV. THEODORE M. HESBURGH, C.S.C.
ROBERT S. RANKIN

ACKNOWLEDGMENTS

This survey would not have been possible without the cooperation of Federal officials and the administrators of State and local facilities and programs visited by staff members of the U.S. Commission on Civil Rights. It was not unusual for officials to interrupt busy schedules to respond to the questions of staff members and to conduct guided tours of program installations. With rare exceptions, these men and women were sincerely interested in understanding the law and its requirements.

Walter B. Lewis, Director of the Commission's Federal Programs Division, and Marian P. Yankauer, Deputy Director of the Federal Programs Division, supervised the following staff members and former staff members in the investigations and preparation of this report: Sara S. Anderson, Mary A. Botko, Robert Cohen, Beverly Cornelius, Dean Determan, Clarence H. Hunter, Brenda M. Jackson, Lulu Jackson, Louise Lewisohn, Jean Lovejoy, Moses Lukaczer, Elisabeth I. F. Murphy, Karen F. Nelson, William C. Payne Jr., James R. L. Robinson, Barney F. Sellers, Richard M. Shapiro, Conrad P. Smith, Gilbert Ware, Roger Warren, Bayla F. White and Katherine V. Wolff.

TABLE OF CONTENTS

PREFACE

The United States Commission on Civil Rights is an independent, bipartisan agency established by Congress in 1957. The Commission, among other duties, has been directed to appraise Federal laws and policies with respect to equal protection of the laws and to serve as a national clearinghouse for information in respect to denials of equal protection of the laws. The Commission reports its findings and recommendations to the President and to the Congress.

On numerous occasions prior to 1964, the Commission recommended that Federal funds be withheld from programs which used the funds in a discriminatory manner. The concept of these recommendations was embodied in Title VI of the Civil Rights Act of 1964.

The Commission assumed new responsibilities with the enactment of the Civil Rights Act of 1964. It cooperated with the Department of Justice and the Bureau of the Budget in a task force effort to assure consistency and enforceability of the regulations issued by the 21 Federal departments and agencies with programs covered by Title VI. The Commission continues to assist many departments with the interpretation of regulations, the development of procedures necessary for the administration of the regulations, and the coordination of programs for the implementation of the Title VI regulations. The Commission also provided staff assistance to the Vice President during the period he was Chairman of the President's Council on Equal Opportunity, the agency which coordinated Federal civil rights activities including Title VI responsibilities.

When, by July 1965, it became apparent that the formal procedures for the enforcement of Title VI had been completed, the Commission turned its attention to an appraisal of whether those procedures were being effective at the local level in areas where the most overt and simple discriminatory practices had previously been widespread in federally assisted programs.

INTRODUCTION

Title VI of the Civil Rights Act of 1964

"Section 601. No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Seldom has any piece of legislation been so broad in scope, sweeping across departmental, geographical, and political lines, as Title VI of the Civil Rights Act of 1964. In simple language, Title VI calls for basic changes in the administration of almost 200 major programs which will receive more than $18 billion in Federal aid during the fiscal year ending June 30, 1966. The programs affected provide services in the areas of education, employment, health care, welfare, housing, agriculture, and business. Federal departments and agencies are directed to issue the necessary implementing rules and regulations and the law provides that funds shall be withheld from those institutions or State programs which continue to discriminate in violation of the law.

Federal financial assistance is in the form of grants to State, county and city governments and local agencies and to private institutions, such as hospitals and institutions of higher education. Some of the money provides for the construction of facilities, hospitals, and health units; some is for training, research, and demonstration projects. County welfare and health offices are examples of the many local institutions whose daily activities are covered by the nondiscriminatory requirement of Title VI. Federal aid helps finance health services to crippled children, pregnant women, and the aged. It helps pay for the rehabilitation and training of the physically and socially handicapped. These funds assist the efforts of individual citizens to increase their education and training for self-sufficiency and to resume normal, active, productive lives.

Before passage of the Civil Rights Act of 1964, federally assisted programs in a number of States had been administered in such a way that some citizens were excluded or provided with inferior services. Some Southern States barred Negroes from certain educational, health, and welfare facilities, segregated them, and provided different treatment because of race or color. Although physical separation was seldom customary outside the South, exclusively white facilities existed along with numerous subtle forms of discrimination in federally assisted programs throughout the Nation.

Several months after passage of the Civil Rights Act of 1964, 21 Federal departments and agencies issued regulations, approved by the

President, which established administrative procedures to implement Title VI.[1]

The termination or withholding of Federal funds is the ultimate sanction for failure to comply. Provision is made for negotiation and persuasion to achieve compliance with the law. The aim of the sanction is not to punish, but to assure that all persons receive the benefits of federally supported programs on an equal basis. The regulations of each department and agency are alike in specifying discriminatory practices prohibited by Title VI:

- Any difference in quality, quantity, or manner in which the benefit is provided
- Segregation or separate treatment in any part of the program
- Restriction in the enjoyment of any advantages, privileges, or other benefits provided to others
- Different standards or requirements for participation
- Methods of administration which would defeat or substantially impair the accomplishment of the program objectives
- Discrimination in any activity conducted in a facility built in whole or part with Federal funds
- Discrimination in any employment resulting from a program with a primary objective of providing employment.

The regulations also require that every applicant for Federal assistance furnish an assurance that the program will be conducted or the facility operated in compliance with certain conditions set forth in the regulations. This assurance takes various forms. In instances of specific grants,[2] it is a simple promise to carry out the federally assisted program in accordance with Title VI and the implementing regulations from the moment of signature. In programs which are State-administered and continue from year to year,[3] these assurances must contain a catalog of any existing noncompliance, establish a deadline for full compliance, and provide a procedure for periodic review. In most cases noncomplying practices were to be eliminated by December 1965.

The regulations of the Department of Health, Education, and Welfare (DHEW) specifically provide that the prohibitions against discrimination "extend also to services purchased or otherwise obtained by the grantee (or political subdivision) from hospitals, nursing homes, schools, and similar institutions for beneficiaries of the program and to the facilities in which such services are provided . . ."[4] Persons or agencies furnishing services are called "vendors", a term used frequently in this study. State agencies or other recipients which purchase services for their programs have designed various forms of assurance of compliance to be filed by vendors as a condition for continued purchase of services. These forms are statements of present

[1] See Appendix A for citations to the regulations of Federal departments and agencies.
[2] Such as construction grants for hospitals, dormitories, and nursing homes; Project Head Start.
[3] Such as State health and welfare programs.
[4] 45 CFR 80.5(a).

compliance and do not provide for any delay in eliminating discriminatory practices. In extending financial assistance to State programs, such as those discussed in the following pages, the Federal Government has relied upon State agencies to obtain vendor compliance.

One year after enactment of the Civil Rights Act of 1964, the U.S. Commission on Civil Rights began a study to determine the extent to which physical segregation had been eliminated from local programs covered by Title VI. The survey was designed to be completed in a short time so as to provide a guide for compliance procedures of the Federal agencies. It was limited to physical segregation of the beneficiaries at the local level because it was in this area that Title VI might be expected to have its earliest impact.

The Commission survey was restricted to the South because physical segregation in Government-financed programs was more prevalent in this section than in other areas of the country. The Commission recognized that more subtle forms of discrimination such as differential quality of service rendered and limited access to certain types of service also are violations of Title VI and require further study.

To conduct this survey, the Commission moved from examination of assurances and procedures in Washington to local communities where programs reached the individual beneficiaries. An immediate indication of the impact of Title VI, for example, would be the physical presence of Negroes (and other minorities in some areas) in places where they previously had been excluded, the presence of Negroes and whites together in institutions where they had previously been segregated, and the use of Negro and white staff to serve all persons without regard to race, where previously there had been racial assignments of staff.

The Commission assessed five federally supported programs[5] which provided services at the local level in more than 40 communities in Alabama, Arkansas, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Virginia. The communities selected for the study included large and small towns and cities; localities with a history of civil rights activity and those with little or no history of such activity; towns with reputations for progress in race relations and towns where there is racial controversy. The communities selected provided geographic diversity and contained a cluster of federally assisted programs or installations.

Commission staff members interviewed local citizens and the administrators of local federally assisted programs and inspected facilities covered by Title VI.

This report describes the degree of compliance with Title VI at the time of field investigations in July, August, September, and October, 1965.[6]

[5] Public health, vocational rehabilitation, welfare, and poverty programs. Hospitals receiving assistance through Federal programs, directly or indirectly, were also reviewed. Educational programs are not included in this study because the Commission plans to issue a separate report on this subject.

[6] All of the facts on the institutions surveyed in this report are based upon investigations of the Commission staff and are the subject of memoranda in the Commission files. Interviews with Federal officials and the telephone checks in January 1966 are also the subject of staff memoranda in the Commission files. The most flagrant cases of discriminatory conduct were reported to DHEW soon after they were noted.

The Commission's field investigation was augmented by a study of the complaint files of DHEW in Washington, information obtained from its regional offices, and interviews with officials of DHEW and the Office of Economic Opportunity (OEO). In January 1966, telephone checks were made with administrators and local citizens, particularly complainants, to determine if there had been any changes in instances where noncompliance had been noted during the field investigation. The results of these telephone checks are reported, where appropriate, in footnotes.

HOSPITALS

Two hospitals epitomize the divergent response to the requirements of Title VI. Prior to 1963, Negro patients at St. Dominic-Jackson Memorial Hospital in Jackson, Mississippi, were housed on the first floor. The hospital's obstetrical ward, delivery room, and nursery were on the second floor of the building. After delivery, Negro mothers were returned to the first-floor Negro ward and their babies were segregated in a separate section of the nursery. Negro fathers could not see their newborn children until they left the hospital because they were not allowed on the second floor. In 1963, the hospital relaxed the rule to permit Negro fathers to view their children in the nursery once—soon after birth. Negro physicians were not allowed staff privileges and Negroes were not accepted as nursing students at the hospital prior to 1965.

Since passage of the Civil Rights Act of 1964, Negro patients are housed on all floors in each wing of St. Dominic-Jackson Memorial Hospital. A Negro physician has been admitted to staff privileges four years after he applied. Negro students are admitted to the school of nursing and to a course in practical nursing. Negro nurses serve all patients throughout the hospital. Negro and white mothers are assigned to the obstetrical section on the second floor. Their babies are cared for in the nursery where neither race nor color have any bearing on bassinet assignments. Negro fathers view their newborn children as often as they wish.

In contrast, Selma Baptist Hospital, a privately owned hospital in Selma, Alabama, continues to exclude Negroes entirely from its services. It has refused to sign an assurance for any federally aided program. The Alabama Vocational Rehabilitation Department no longer sends patients there. The Alabama welfare program which has refused to file a statement of compliance continues to pay for the care of white welfare patients at Selma Baptist. The hospital administrator told the Commission staff he had no plans to comply with Title VI. The hospital board had discussed Title VI in relation to the future requirements of the Medicare Program without taking any action, he reported.

These cases were noted in a survey during which staff members of the U.S. Commission on Civil Rights visited 39 hospitals in large cities, rural communities, and small towns.

Each hospital visited received direct financial assistance from the Federal Government such as Hill-Burton[1] construction funds or money for training and equipment, or indirect financial assistance, such as payments for services rendered to participants in health and welfare programs financed by Federal money.[2] All but two of the hospitals

[1] The Hill-Burton Act is Federal legislation under which the Federal Government makes grants-in-aid to the individual States for the construction and remodeling of health and hospital facilities. 42 U.S.C. 291–291o (1964).

[2] The extent of Federal financial assistance will increase considerably with the Medicare Program under which payments will be made to hospitals for care of the elderly.

visited had filed an assurance of compliance with DHEW. Complaints alleging violations of Title VI had been filed against a few of the hospitals visited by Commission staff.

Eleven of the institutions visited by Commission field teams had made significant changes in their discriminatory patterns of patient assignment, staff assignments, and access to public facilities since DHEW issued the Title VI regulations in December 1964. Varying degrees of desegregation were evident at other hospitals, while still others continued to operate under discriminatory policies. Four of the institutions visited were all-Negro hospitals.

HOSPITALS WITH NONDISCRIMINATORY PRACTICES

Commission staff members found instances of successful desegregation of facilities and services at large and small, public and private, specialized and general hospitals. These hospitals were in towns and cities of the South as well as in border communities. They served the same general areas as hospitals which had made no apparent efforts to desegregate.

Two hospitals surveyed, Peninsula General Hospital in Salisbury, Maryland, and James L. Kernan Hospital for Crippled Children in Baltimore, had achieved substantial desegregation prior to passage of the Civil Rights Act.

Shortly after signing assurances of compliance, Mobile General and Providence hospitals in Mobile, Alabama, desegregated wards, two-bed rooms, clinics, and public facilities. Each hospital is of approximately 250-bed capacity and desegregation was accomplished within a few days wthout incident. At the time of desegregation, Negroes accounted for 70 percent and whites for 30 percent of Mobile General's patients while whites were 85 percent and Negroes 15 percent of Providence Hospital's patient census.

The 453-bed Medical College Hospital in Charleston, South Carolina, desegregated its rooms, wards, and staff assignments in a series of changes which had been discussed at regular meetings between the hospital administration and local civil rights leaders.

Milledgeville State Hospital in Milledgeville, Georgia, desegregated accommodations and services for 12,000 mental patients and staff assignments and living quarters for 3,000 employees, under a series of steps planned in March and April 1965.[3] Cherry Hospital, a 3,300 bed all-Negro mental institution in Goldsboro, North Carolina, was desegregated when Negro patients were transferred to formerly white facilities and replaced by white patients on a nondiscriminatory basis. Cherry Hospital's predominantly Negro staff was being augmented by white employees when the Commission staff members visited the facility in August. Staff responsibilities and living accommodations were being assigned on a nonracial basis.

[3] A copy of the plan will be found in Appendix B.

Chickasawba Hospital in Blytheville, Arkansas, and Memorial Hospital in Marshall, Texas, assigned white and Negro patients to two-bed rooms without racial consideration and desegregated their public facilities. Neither hospital has ward accommodations.

Negro children had been excluded from Crippled Children's Hospital School in Memphis, Tennessee, prior to 1954 and then admitted on a rigidly segregated basis until 1964. The Commission staff members who visited the hospital in August found the facilities desegregated. The head nurses had explained the law and the change in policy to visiting parents.

Three rural Northeast Mississippi hospitals without ward accommodations, Tippah County Hospital in Ripley, Houston Hospital in Houston, and Northeast Mississippi Hospital in Booneville, had announced publicly that their new policies required the assignment of patients to two-bed rooms without regard for the race or color of the occupants. None of the hospitals was operating at full capacity in mid-September. No patient occupied a room with another patient at that time of the Commission inspection.

Commission staff members noted desegregated rooms and wards, including the obstetrical ward, when they visited Richmond Memorial Hospital at Richmond, Virginia, in July. Segregation was still in evidence in the nursery, however, where Negro babies were kept in a separate room. The hospital also administers Sheltering Arms, a nonprofit, privately endowed charity hospital for the medically indigent which had previously accepted only white patients. The hospital administrator said a new policy allowed the admission of Negro patients to Sheltering Arms. Only one Negro had been accepted as a patient, however.[4]

HOSPITALS WITH DISCRIMINATORY PRACTICES

The Commission investigation found that some hospitals continued to operate on a racially discriminatory basis even though the institutions had signed assurances that they were in compliance with Title VI.

Hospitals With More Than One Building

There are four separate buildings—Medical College of Virginia Hospital, St. Philip Hospital, Memorial Hospital, and E. G. Williams Hospital—in the Medical College of Virginia hospital complex in Richmond. St. Philip, a 177-bed facility across the street from Medical College of Virginia Hospital, was built in 1919 for Negro patients. In July 1965, it still was used only for Negroes. Officials of the hospital told Commission representatives that St. Philip patients requiring surgery or other medical services not available at St. Philip were taken

[4] In January 1966 the administrator of Richmond Memorial Hospital reported that the nursery was desegregated soon after the Commission field team pointed out that Negro babies were confined to one room of the hospital nursery. He also reported a slight increase in the admissions of indigent nonwelfare Negroes to the formerly all-white Sheltering Arms.

to Medical College of Virginia or other hospitals in the complex for the necessary service and returned to St. Philip. Negroes were admitted to the Medical College of Virginia Hospital emergency room or any other unit in the hospital depending upon the requirements of their condition. However, Negro patients who received emergency treatment at Medical College of Virginia Hospital were transferred to St. Philip as soon as their condition permitted. Patients were assigned to E. G. Williams Hospital for tubercular and other special care on a nonracial basis, the hospital director said. The director of hospitals told Commission staff members that no white patient would be assigned to St. Philip if he objected to it.[5]

When Commission staff members visited Craven County Hospital in New Bern, North Carolina, in September, they found that patients were assigned to four- and six-bed wards on a racially segregated basis. Commission representatives were told by the hospital administrator that white and Negro patients had occupied semi-private rooms together "on occasion". Craven County Hospital also operates Good Shepherd Hospital, a 58-bed, all-Negro institution it acquired in 1964 from the Episcopal Diocese of North Carolina. When visited by Commission staff, this facility was occupied by 20 Negroes and one white patient. The administrator said that the white patient had been transferred to Good Shepherd "for financial reasons".

At the time of the Commission investigation, James Walker Memorial Hospital in Wilmington, North Carolina, which had been involved in a decade of litigation over its segregated facilities, continued to maintain a building for Negro patients at the rear of the main facility. Negro patients were wheeled from the separate structure into the main building for surgery and other services. Some Negro patients were housed in segregated wards in the main building. The hospital also made staff assignments according to race although the administrator said some Negro nurses had been assigned to care for white patients since passage of the Civil Rights Act.[6]

In August 1965, the 484-bed Macon Hospital in Georgia had made only minimal changes to comply with Title VI provisions. After passage of the Civil Rights Act, the hospital converted its formerly all-Negro building into a facility for welfare patients only. Negroes account for 60 to 70 percent of the welfare patient load. No Negro and white patient occupied the same room or ward in this building

---

[5] The administrator reported in January 1966 that since the Commission field investigation the Medical College of Virginia has created a central admissions office with procedures designed to assure nonracial room assignments, renamed the buildings in the complex to eliminate associations with former racial assignments, and assigned staff patients of both races to the formerly all-Negro building. (Staff patients are those treated by physicians on the hospital staff and usually are admitted without a private physician.) A six-man DHEW field team had inspected the Medical College of Virginia complex after the Commission had reported its initial findings to the Department.

[6] In January the administrator reported that James Walker now houses Negro and white welfare patients in the same 4-bed rooms in the formerly Negro building and the wards have been desegregated in the main building. These changes, confirmed by telephone calls to interested citizens in the area, occurred as a result of intensive work by a DHEW field team which visited the hospital after the Commission reported its initial findings to DHEW.

at the time of the Commission staff visit.[7] The hospital administrator told Commission staff members that welfare patients were assigned to beds without regard to race or color. He explained that white and Negro welfare patients did not occupy the same rooms because white patients "found the money" to afford semi-private or private accommodations when Negroes were moved into the same room or ward. In the formerly all-white building, there were 56 nonwelfare Negro patients, none of whom occupied rooms with whites.

State or City-wide Hospital Systems

In addition to discrimination in hospitals administering several buildings, the Commission study found racial discrimination practiced by some State and municipal hospital systems which operate separate hospitals at different locations.

Virginia's Negro mental patients are confined to Central State Hospital at Petersburg, an overcrowded institution lacking in specialized facilities. The State's white mental patients are assigned to a variety of institutions throughout the State which are capable of providing specialized services. Alabama's mental hospitals are under the control of the administrator of Bryce Hospital, the largest institution in the statewide system. Bryce, a rigidly segregated institution in Tuscaloosa, serves 5500 patients, approximately two-thirds of whom are white. Searcy Hospital, an all-Negro facility near Mobile, serves 2700 patients. Partlow State School and Hospital, located a few miles from Bryce, is the State's only institution for retarded children. It is extremely overcrowded and maintains rigid segregation between its white and Negro patients. No Negro children have been included in an experimental "Total Push" program in which white children are given special care.

The city of Memphis, Tennessee, maintains E. H. Crump Memorial Hospital as a separate unit of its municipal hospital system. Crump Memorial accommodates Negro paying patients only. Virtually no paying white patients have been admitted to Crump, despite some desegregation in other hospitals operated by the City of Memphis.

In assessing the failure of these government operated hospitals to desegregate, it is worth noting their similarity to Milledgeville and Cherry hospitals, State mental institutions in Georgia and North Carolina, which transferred thousands of patients and personnel in order to comply with Title VI. In these two instances, within a few months all living arrangements, treatment, and service centers were desegregated without incident. In the case of the segregated Government hospitals noted above, all the patients and facilities are under the jurisdiction of one Government official with responsibility for compliance with Title VI. No action by private physicians or other officials is required to desegregate Government hospitals. None of the four institutions had as yet embarked upon initial planning to com-

[7] This hospital was the subject of a complaint to DHEW in February 1965. DHEW investigated the complaint and the hospital was reported to be in total compliance in June 1965. Subsequently it was removed from the complaint list, making it eligible for grants.

ply, and none had submitted to DHEW a plan which had been approved. The administrators interviewed were unfamiliar with the requirements of the law or of the plans of State officials in regard thereto.

Single Building Hospitals

The Commission investigation found that the pre-Civil Rights Act pattern of discrimination consisted of a separate wing or floor for Negro patients. Where there were four-bed and two-bed accommodations in the hospital, these were provided separately within each segregated wing. In the summer and fall of 1965, field visits showed that one of the first effects of the Civil Rights Act was the elimination of separate Negro floors and wings in most hospitals. But race had by no means disappeared as a factor in room assignments. Although Negro patients could be assigned to all floors and sections of a hospital, they continued in many instances to be confined to racially restricted wards or rooms.

A. State Hospitals With Ward Accommodations

There was racial segregation of patients at Hale Memorial Hospital in Tuscaloosa and Sixth District Hospital in Mobile, two Alabama State institutions for the care of tubercular patients. Waiting rooms and the nurses' dormitory were desegregated at Hale Memorial and the hospital administrator told a Commission field team in late September that he was awaiting instructions to proceed with further desegregation. He explained that he had "warned" staff members and patients that "desegregation was coming". White and Negro patients were housed on separate floors at the Sixth District TB Hospital, but the basement cafeteria was desegregated. The administrator reported he anticipated that desegregation of the 16-bed ward would be achieved as the patient load increased in the winter. Both of these hospitals are under the jurisdiction of the State Department of Health which has submitted a plan for compliance. The TB hospitals are not included in this plan, which has not been accepted by DHEW.[8]

B. Local Hospitals With Ward Accommodations

Memorial Hospital of Wake County in Raleigh, North Carolina, was built with Hill-Burton funds four years ago as an all-Negro institution to accommodate patients who had been housed in an over-

[8] The medical director of Hale Memorial Hospital corrected information he gave during the September field inspection when he told a Commission field team that only Negro patients were accommodated on the hospital's third floor. At that time and in January there were Negro patients on each floor including the third floor, he said. Early in January there were three whites among 40 female patients on the third floor, he reported. The administrator said he had received no information about a State plan to aid him in further desegregation of the hospital.

The administrator of the Sixth District TB Hospital in Mobile reported that, except for the single white male patient on the Negro floor, the hospital's patients remained segregated according to race. He, too, said that he did not know of any State plan for Title VI compliance.

crowded, inadequate, segregated structure. The new hospital, however, never had enough Negro patients to fill its 315 beds and at the present time more than 50 percent of its patient population is white. The hospital maintained racial segregation in its room and ward assignments at the time of the Commission investigation in July. The desegregation of the hospital's facilities was limited to the pediatric clinic, nursery, waiting rooms, cafeteria, and snack bar.

Helena Hospital in Arkansas had eliminated a separate Negro wing but continued to assign patients to rooms and wards on a segregated basis.

Laurens County Hospital in Dublin, Georgia, had desegregated wards housing welfare patients but had not assigned a Negro and a white patient to the same semi-private room at the time of the Commission survey in July.

When visited in September, the Community Hospital in Corinth, Mississippi, which had signed an assurance of compliance, had all its Negro patients segregated in the basement of the hospital building and maintained complete segregation in all its facilities. The administrator said that he did not intend to desegregate until the institution moved into new quarters which were then under construction. The new building, somewhat larger, was to be called Magnolia Hospital and was being built with Hill-Burton construction funds. The hospital had signed an assurance of compliance in order to receive Hill-Burton funds from the Federal Government.[9]

C. Local Hospitals With Only One and Two-Bed Rooms

Several hospitals included in the Commission survey provided only semi-private or private accommodations while two others were in the process of converting their ward and other multiple-bed facilities into private and semi-private accommodations.

Druid City Hospital in Tuscaloosa, Alabama, is converting its four-bed rooms into two-bed rooms and its semi-private rooms into private accommodations. Toilet facilities which formerly served two rooms are being converted to private or semi-private room use. The room conversions will result in substantially fewer accommodations in the 355-bed institution. At the same time, the hospital is building a 60-room addition financed with Hill-Burton funds.[10] In late September the hospital administrator told the Commission field team that a Negro and white patient probably never would be assigned to the same semi-private room.

In Eutaw, Alabama, the 26-bed Greene County Hospital was engaged in a similar remodeling program to convert all accommodations

---

[9] In January 1966 Community Hospital in Corinth had closed its doors and transferred all patients to the new Magnolia Hospital. The hospital administrator reported that Negroes occupied rooms on all floors and in all wings of the new facility but he did not know if a Negro and a white patient occupied the same room.

[10] The Hill-Burton Project Register of June 1965 lists this addition as providing 106 beds. The administrator stated that he intends to operate this addition as 60 private rooms, though each room is large enough to accommodate a second bed if the need arises.

to private rooms. The hospital administrator told the Commission field team that he would not make nonracial room assignments. At the same time that the hospital was reducing its number of available beds, it was constructing a 30-bed nursing home with Hill-Burton funds.

In Marion, Alabama, the Perry County Hospital and Nursing Home had taken steps to file an assurance and to begin compliance at the time of the Commission field visit. The administrator said he hired a guard in anticipation of trouble under the new procedures to protect the whites from "all these Negroes roaming around" in the 46-bed hospital. At the administrator's invitation, Commission staff members attended a meeting of the hospital's white employees at which he discussed the necessity of complying with the Civil Rights Act. At the same time he emphasized his opposition to the law and his belief that it would be harmful to the hospital program. He said that the hospital's Negro employees had been informed of his decision at a separate meeting.

Pontotoc Community Hospital in Pontotoc, Mississippi, which provides semi-private accommodations only, had eliminated its separate Negro wing and Negro patients were assigned to segregated rooms throughout the facility. The hospital administrator told Commission staff members that semi-private rooms would not be desegregated unless he was compelled to do it.[11] Jefferson Hospital in Pine Bluff, Arkansas, had eliminated separate Negro wings, but continued to make racial room assignments.

The Webster County Hospital in Eupora, Mississippi, had eliminated its Negro wing and the hospital administrator reported to Commission staff that he intended to end segregated room assignments when the hospital was operating at capacity. He apparently meant that a Negro would not be assigned to a room with a white patient unless there were no empty rooms in the hospital. A half curtain, formerly used to separate white and Negro babies in the nursery, continued to be used to separate "difficult" babies from the other infants, the Webster County administrator explained. There were no babies in the nursery at the time of the Commission visit.

Even Mississippi's St. Dominic-Jackson Memorial Hospital, which has made substantial changes in its racial policies, does not assign Negro and white patients to the same room except in emergencies.

It should be noted that the continuation of racial room assignments may sometimes result in making medical care less accessible. Historically, where Negro patients were confined to a separate building or floor and these accommodations were filled, Negro patients were placed in the halls or in rooms which already were overcrowded. When crowding became too great, Negroes could not be admitted for hospital care. This had occurred when beds were empty in the white section of the hospital. The continued practice of confining Negroes to rooms or wards which house other Negro patients, even though on

[11] Despite his flat statement that he would not assign a Negro and white patient to the same room, the administrator of Pontotoc Hospital reported in January that he was making such assignments. He cited one instance of a nonracial room assignment since the Commission field investigation.

all floors of the building, does not eliminate the danger of past practice. It places a limit upon the accessibility of hospital beds for the care of both white and Negro patients if it is applied strictly to both races so that each must always await a vacant bed in a room with a person of his own race.

Officials of Confederate Memorial Medical Center in Shreveport, Louisiana, refused to talk with Commission staff members or to allow them to inspect the premises.[12] The staff members noted, however, that the hospital's waiting rooms were segregated. The hospital serves welfare patients and has signed an assurance of compliance with Title VI.

All-White and All-Negro Hospitals

Four private hospitals in the Commission study, either through custom or policy, have only white or Negro patients. Because most patients are referred to these hospitals by physicians, these institutions need the cooperation of physicians if they are to have a biracial patient population.

The presence of noncomplying hospitals in a community presented difficulties for administrators of desegregated hospitals or administrators who sought to comply with Title VI. In some instances, hospital administrators said they experienced a decrease in white admissions after their institutions were desegregated. They attributed this decline to the fact that physicians were assigning white patients to all-white hospitals which were not in compliance with Title VI.

Good Samaritan Hospital in Selma, Alabama, and St. Martin DePorres Hospital in Mobile, for example, are operated by religious orders and have been used by Negro patients only. Both institutions filed assurances of compliance with Title VI but have received virtually no white patients. Most of the white physicians on the staff of Good Samaritan also are members of the staff at the all-white Selma Baptist Hospital but have not referred white patients to Good Samaritan despite the fact that Good Samaritan is anxious to accommodate whites.

At the time of the Commission field investigation, the 500-bed Mobile Infirmary, the largest general hospital in Mobile, Alabama, continued to be operated almost exclusively for white patients. No Negroes had been admitted to the hospital as patients prior to the time the hospital signed the Title VI assurance of compliance in the spring and only 14 Negro patients had been admitted by September 30, 1965. Recently one Negro physician was admitted to the staff.[13]

---

[12] DHEW officials who visited the hospital to investigate complaints against the institution also were barred from the premises.

[13] The administrator reported in early January that Mobile Infirmary had admitted an additional 25 Negroes as patients since the Commission field investigation. A second Negro physician had been added to the professional staff and two Negro nurses had been hired.

SUMMARY

In the summer of 1965—one year after passage of the Civil Rights Act and six months after the regulations requiring desegregation of hospitals—staff members of the United States Commission on Civil Rights visited 39 hospitals in 11 Southern and border States to determine the effect of the law and regulations upon segregation of patients in hospitals. Two of the hospitals in the survey, both in Maryland, and desegregated substantially before passage of the Civil Rights Act. Only eleven of the remaining hospitals visited had achieved any substantial degree of desegregation in the year after the Act was passed.[14] A few had made significant changes but had not eliminated all discriminatory practices. In nearly two-thirds of the hospitals surveyed, there were discernible patterns of noncompliance. No substantial change had occurred in patient admissions or assignment to rooms and wards. In all but a few cases, Negro wings or floors within the hospital building had been eliminated, but integration of patients within wards was less frequent, and biracial assignments to two-bed rooms was the most difficult step for administrators to take.

State hospitals and State institutions were still segregated even though under control of a State agency with responsibility for securing compliance from private hospitals. The two outstanding exceptions to this were large State mental hospitals which desegregated quickly. However, size of the institution was no indication of successful desegregation. Some small hospitals had taken positive action. Several hospital complexes which included more than one building remained segregated and their administrators moved hesitantly to correct these situations. The pace at which hospitals had desegregated was primarily determined by the administrator or board and was seldom the result of efforts by the Public Health Service (PHS) staff of DHEW.

[14] In January 1966 telephone checks with hospital administrators indicated that four additional hospitals had made substantial changes which would probably bring them into compliance. At several hospitals changes had occurred after reinspection by PHS teams which had received reports of Commission findings.

PUBLIC HEALTH CENTERS

Public health clinics are maintained throughout the country, usually on a county basis. The Public Health Service and the Children's Bureau of the Department of Health, Education, and Welfare make grants-in-aid to State public health departments which finance services in the local communities. In addition to environmental health work, local clinics provide immunizations, prenatal and well-baby care, and varying degrees of chronic disease care. Heart and cancer detection clinics are also part of the public health program, and, in some counties, dental care is provided to the needy. Usually, the public health program is administered by a county board of health and directed by a health officer, ordinarily a physician. Public health nurses, nutritionists, and sanitarians are hired as professional staff for the programs. Public health clinics are staffed by local physicians.

In some health centers visited, the Commission staff members noticed striking racial differences in the patient loads, even though there were large numbers of both whites and Negroes in the income group eligible for these services. In a few instances, patients in heart and cancer clinics were predominantly white. In one county, the dental clinic served only white children while in another county, three-fourths of the patients were white. On the other hand, in a number of communities, prenatal and well-baby clinics were exclusively or predominantly Negro. The reason for these differences is not known.

Among the public health programs providing clinics on the local level, the maternal and child health program for prenatal and well-baby services receives the most direct Federal assistance through the Children's Bureau of the Welfare Administration. To this office the State health departments report regularly on the number of women and children receiving care under the program. For six Southern States this information is provided by race and indicates that from five to ten times as many Negro as white mothers receive prenatal care in clinics. In some States the licensing of untrained midwives is also a function of the local health department and State law requires that women delivered by untrained midwives supply a certificate that they received prenatal care.

In Selma (Dallas County), Alabama, where there were equal numbers of white and Negro families with incomes below $3000 in 1960, the health officer told Commission staff members that only Negroes participated in the prenatal program. He said he did not know where white women in the same income group received prenatal care. In 1963, 1600 babies were born to residents of the county. All but four of the 600 white babies were born in hospitals with physicians in attendance, but only 300 of the 1000 Negro babies born in the county were delivered in hospitals with physician care. Seven hundred Negro babies were born outside hospitals, most attended by midwives.[1]

[1] In the county the same year the rate of infant deaths under 28 days was 13.2 for whites per thousand and 32 for Negroes. U.S. Department of Health, Education, and Welfare, Public Health Service, *Vital Statistics of the United States, 1963*. Figures for the counties do not identify attendant, but for the State of Alabama as a whole, indicate that 10,000 out of 11,000 Negro births outside hospitals were attended by a midwife.

Although it is not known how poor white women receive prenatal care in Selma, it was apparent that the care they receive outside the public health program results in the birth of their babies in hospitals with a physician in attendance. On the other hand, the federally assisted public health program which provides care only for Negroes, resulted primarily in the birth of babies outside hospitals attended only by untrained midwives. Another aspect of the public health program is a special project grant which provides for the hospitalization of complicated pregnancies. The health officer of Dallas County said that pursuant to directives of the State Health Department, all his complicated pregnancy cases were sent to Tuskegee, 100 miles away, for admission to the John A. Andrews Memorial Hospital, a predominantly Negro institution.[2]

Dental care is another part of the public health program in Dallas County and one which, prior to 1965, had been limited to whites. Early in the summer of 1965, a Negro youngster went to the Dallas County Health Center in Selma, Alabama, and asked for someone to look at his teeth. An attendant gave him an appointment and when he returned a few days later, a dentist repaired his teeth. This marked the first time a Negro had been cared for at the Dallas County Dental Clinic.

A few days later, several Negro children sought dental care at the clinic. At this point the county health officer adopted a new procedure for treating children and announced that dental care would be provided school children on a school-by-school basis.

Appointments were made through the schools and children were treated in their schools rather than at the clinic. Although Negro children were included in the county dental program for the first time, this new procedure assured that the treatment would be largely on a segregated basis.[3]

Some health clinics and departments attempted to achieve compliance with Title VI by removing racial signs from entrances, waiting rooms, and other public facilities of buildings and offices. Others abolished separate treatment days for white and Negro clients. But deeply entrenched practices of racial separation continued as Negroes and whites segregated themselves at some facilities. At the Bibb County Clinic in Macon, Georgia, the Commission field team noted that white women awaiting prenatal care stood in the hallway while Negro women were in the waiting room. The Baldwin County Health Department removed the racial sign from the former Negro entrance to the Marion Enis Health Center in Milledgeville, Georgia, but Negroes continued to enter the clinic through that door only. The

---

[2] Inquiry to the Regional Office of the Children's Bureau in Atlanta revealed that many other hospitals in Alabama, including county hospitals, provide care under the program. The regional representative, however, said he did not know if any hospital nearer than Tuskegee provided this care. The State Health Department reported that the predominantly Negro hospital at Tuskegee "may admit cases from any county in the state," and the director of the hospital said he admitted cases from 29 counties.

[3] When Selma schools opened for the Fall 1965 term, there were only 31 Negro pupils who had signed up to attend previously all-white schools under the city's "freedom of choice" school desegregation plan.

Hinds County Health Clinic in Jackson, Mississippi, removed racial signs from its waiting rooms, entrances, drinking fountains, and rest rooms, but left standing a masonry partition dividing the main waiting room. Despite a sign which proclaimed that "All guests and those coming here for service sit where they like," Negro and white patients sat on opposite sides of the partition. In the Tuberculosis Clinic, Negroes and whites continued to wait in separate alcoves according to race even though the old racial signs were no longer there. The removal of racial signs in the Dallas County Health Department clinic did not prevent Negroes and whites from continuing to use separate entrances and waiting rooms.

Other health centers and clinics had been successful in eliminating customary practices of racial separation. Patients attending the Laurens County Clinic in Dublin, Georgia, for example, used all physical facilities without racial considerations in a building which contained dual accommodations. The clinic was desegregated two years before passage of the Civil Rights Act by a new health officer who had been administrative head of a large nearby Veterans Administration Hospital which was desegregated in 1952. The Commission field team found no evidence of physical segregation at health clinics in Corsicana, Austin, and San Antonio in Texas; Raleigh and Rocky Mount in North Carolina; Charleston, South Carolina; Blytheville and Pine Bluff in Arkansas; and Tuscaloosa and Mobile in Alabama.

Some of the clinics which had achieved physical desegregation had failed to eliminate procedures which resulted in Negro and white clients being treated on different days. In Tuscaloosa, for example, where the county health department had eliminated the designation of immunization clinics as "white" and "colored", Negroes continued to visit the clinic on "their Tuesday", the health officer reported. He commented to Commission staff members that "Thursday (former immunization day for whites) is becoming integrated."

The Commission study found some instances of desegregated staff assignments at some of the clinics and health centers visited during the survey. In Tuscaloosa, for example, a Negro physician assigned to the well-baby clinic reported he had served a white mother and child for the first time. In Mobile, Commission staff members were told that Negro nurses had innoculated white patients even though they had been asked not to "force the issue" if a white patient voiced an objection. The Mobile County health officer reported Negro and white dentists had worked together successfully for the first time in the health center's Project Head Start program. At the well-baby clinic in Raleigh, Negro and white nurses served Negro and white mothers and children without racial distinction. By contrast, at the Edgecombe County Health Center in Rocky Mount, a Negro nurse with 20 years' experience reported she rarely served a white patient. At the Bibb County Clinic in Macon, where staff desegregation was achieved by the alphabetical assignment of desks, a Negro physician served only Negro mothers in his well-baby clinic and a white physician served white patients at a different time. During the summer of 1965, however, a Negro physician for the first time examined a white baby at the clinic.

The Negro nutritionist employed by the Harrison County Health Clinic in Marshall, Texas, did not serve white clients. Until late 1964 the only Harrison County health service had been a maternal and child care unit for Negroes in a segregated building. When the county health department was organized, it absorbed the maternal and child care unit. But the new clinic was organized in such a way that the Negro nutritionist and Negro secretary from the old unit were located in a room on a floor separate from the white women staff members. Racial designations of public facilities in the building were removed after the Commission staff reported them to the State health department.

SUMMARY

The Commission investigation disclosed that many county public health departments had ended enforced segregation of their facilities and services immediately after, if not before, passage of the Civil Rights Act. This had not been successful in breaking the habits of years of enforced racial segregation because Negro and white clients continued to use the customary entrances, waiting areas, and public facilities. The maintenance of dual facilities, though unmarked, apparently encouraged their continued use on a racially restricted basis. Again, as noted in the hospital review, compliance with Title VI depended to a great degree upon the individual initiative, understanding, and dedication of the administrator.

In several counties, Commission staff members noted differences in the racial clientele of certain clinics.

PUBLIC WELFARE

State public welfare departments, assisted by Federal grants,[1] provide financial assistance, counseling, and service to the aged, dependent children, the blind and totally disabled, as well as to individuals who need general public assistance. Local welfare departments also purchase or contract with local physicians, agencies, and institutions for services for their clients, particularly medical, hospital, and nursing care, special education and training for the handicapped, institutional and foster home care for children and the aged, and rehabilitation services in all these categories.

Federal agencies have no direct contact either with the welfare recipient or the local institutions which provide care and services. The effectiveness of Title VI, in making services available to Negroes and in eliminating discriminatory practices among the vendors [2] who supply service to welfare clients, depends to a great degree upon State and local welfare administrators who deal directly with the vendors. The vendors must file assurances of compliance with State departments of public welfare who in turn must furnish statements of compliance to the Welfare Administration of DHEW.

In its field survey, the Commission staff, in addition to inspecting the offices of the local welfare departments, endeavored to determine the extent to which vendors had been informed of the requirements of Title VI and whether the local welfare offices had taken steps to assure that discriminatory practices would be eliminated.

Medical Care [3]

At the time of the field survey, welfare programs in several States visited were financing medical care on a discriminatory basis for their clients. These programs used the services of private physicians who maintained segregated offices, scheduled different treatment days for patients of different races, and referred patients to hospitals on a racial

---

[1] Federal grants cover from 73 to 82 percent of the cost of various State programs. Two programs illustrate the situation. In the program for the Aid to Families with Dependent Children, the range is from a low of 76.6 percent in Virginia to a high of 82.4 percent in Florida. In the Old Age Assistance program the low was 73.8 percent in Louisiana and the high 81.6 percent in Mississippi. (Figures for Fiscal Year 1964. U.S. House of Representatives, Subcommittee of the Committee on Appropriations, 89th Congress, 1st Session, *Hearings on the Department of Health, Education, and Welfare Appropriations for 1966.* Part 1, p. 997.)

[2] Vendors of service are those from whom a State program purchases or contracts for service to its clients by making direct payments to the individual or institution furnishing the service. See a detailed discussion of the applicability of Title VI to such vendors on page 2.

[3] The provision of medical and hospital care for welfare patients varied widely in the States visited. In several States such care was for all welfare recipients. In other States, medical and hospital care was available only to the aged and the handicapped. When medical care was part of the public welfare program its method of financing varied from State to State. North Carolina, Tennessee, and Texas made payments to the welfare recipient, who in turn paid physician's fees. Other States made direct payments to physicians for care rendered to welfare patients. In the latter case, Title VI prohibitions applied to the provision of service by physicians.

basis. This was exemplified by an advertisement in the August 29, 1965 issue of *The Shreveport Times:*

> Effective September 1st 1965 we are limiting our practice to those white and colored patients and families who prefer the dignity and privacy of segregated waiting rooms.
>
> We assure you all that there has never been, and never will be, any discrimination in our treatment of sick patients because of race, color or creed.
>
> (Physicians' names Deleted)

Members of the Commission staff who visited Louisiana in August found that the local welfare director sympathized with the views of the physicians who placed the newspaper advertisement. To be paid for services to welfare clients, Louisiana physicians must sign a form issued by the State welfare department indicating that they have treated the particular welfare patient without regard to race. The local welfare director indicated she would not discourage welfare clients from visiting a physician who segregated his patients. Some physicians, she told the Commission field team, had indicated they would serve welfare clients free of charge rather than sign the statement of compliance.

The Georgia State Department of Public Welfare informed its local administrators of their responsibility to assure that physicians who serve welfare clients comply with the law. In a letter of August 9, 1965, the department advised local welfare administrators:

> "Effective immediately, in the course of your regular activities, you will seek information concerning compliance of physicians used in the programs, and be alert to discover instances of discrimination. Physicians have the option to serve whomever they please, but if they elect not to serve applicants or recipients of our programs on a nondiscriminatory basis, the use of their services must be discontinued."

The Commission's Georgia field visits occurred a week after local welfare administrators received the letter, too soon to make a judgment of the effectiveness of this procedure.[4]

Local welfare directors in Arkansas understood that Title VI forbade racial segregation in the offices of physicians who treated patients under federally assisted programs. But they were uncertain about the

[4] See footnote 6, page 22.

nature of vendor coverage and their responsibilities for achieving compliance. In Blytheville, Arkansas, the director of public welfare told Commission staff members that the county's physicians would not accept welfare patients because payments were too low. The director of child welfare, however, reported that his agency referred clients to local physicians. He said he did not know whether or not the physicians segregated their patients. A Commission staff visit to a nearby physician's clinic used by the program revealed the segregation of patients.

When visited in September, the Mississippi State Welfare Department had prepared a clause, similar to that used to certify nondiscrimination in Louisiana, to be inserted in the statement regularly signed by physicians serving welfare patients. It was intended that such a form would be put into use in November. The State director recognized that segregated care in physicians' offices was a fairly widespread practice.[5]

Hospitals

Many of the hospitals discussed in an earlier chapter were vendors of service to welfare clients and there was substantial failure to comply with Title VI in some of these institutions.

Most State departments of welfare secured assurances of compliance from hospitals which served welfare patients. Lists of approved hospitals were sent to local welfare administrators, but neither State nor local welfare officials knew the extent to which hospitals had actually changed their practices.

The four Mississippi agencies, including the State welfare department, which purchase hospital care for their clients issued a joint statement explaining to the cooperating institutions the need for nondiscriminatory treatment. Of the 250 hospitals used by the agencies, 30 refused to sign nondiscriminatory pledges and were excluded from the program. The welfare administrator in September said that she did not know how much actual change had taken place in the segregation practices of the hospitals which had signed.

In Arkansas, Georgia, Louisiana, and Tennessee, local welfare directors were aware of hospitals which had signed assurances with the State Departments, but not familiar with the actual practices of the hospitals. There were a few instances of hospitals being dropped because of their refusal to sign assurances. In Memphis, Tennessee, however, the welfare director listed the Methodist Hospital as a vendor, although it had not signed an assurance.

In Texas, only one out of 650 hospitals had refused to sign an assurance. In a move to create public understanding of the law, the Texas Department of Welfare had sent notices to all physicians in an eight-county area and to all old-age recipients in the area informing

---

[5] In January, the Mississippi Commissioner of Public Welfare reported that the nondiscrimination clause has now been included in the usual certification signed by physicians, and that there has been no substantial objection to this. Limited hospital and physician care are the only vendor services that are used in the Mississippi welfare program.

them that payments could no longer be made for care in this hospital. The notice carefully reiterated the requirements of the law.

Nursing Homes and Child Care Institutions

The Commission field staff found extensive racial segregation in nursing homes and child care institutions, including facilities which excluded Negroes as well as those designated for Negroes only. In Americus, Georgia, for example, elderly white welfare patients accounted for one-half of the patient population of the Magnolia Nursing Home. Neither Magnolia nor any other nursing homes in the county admitted Negroes. In nearby Milledgeville, the welfare director did not know if any nursing home had changed its policy of racial exclusion as a result of the nondiscriminatory requirement of Title VI. She reported also that maternity homes remained segregated.[6]

A local welfare director in Louisiana indicated there had been no change in the operation of segregated nursing home facilities. The welfare director contended that the Negro welfare clients who were cared for at a Negro nursing home in the parish received better nursing home care than white welfare patients in the parish. "I often thought that when I retired I would just black my face and go there [the all-Negro nursing home] but it will probably be integrated by then and it won't be worthwhile," the director told Commission staff members.

Local welfare departments in Arkansas continue to make referrals to the State Training Schools despite the fact that they are segregated. There are no facilities for the placement of Negro children in some counties in Georgia and North Carolina[7] because of racially restrictive policies and practices. Welfare administrators said they had not devised plans to alleviate the situation.

Segregation in Local Offices

Most of the public welfare offices visited by the Commission staff had desegregated their waiting rooms or public facilities, and only four offices visited were located in segregated courthouses. Mississippi,[8] North Carolina, and Texas officials indicated that some changes in buildings would be necessary before compliance could become a fact. In Shreveport, Louisiana, the welfare office had removed its signs designating separate waiting rooms, but the room was divided by a solid partition, with Negroes and whites sitting on separate sides. The director claimed that the clients preferred the segregated arrangement.

[6] Two county offices in Georgia were checked in January to determine if any changes in admissions to nursing and maternity homes or other vendors of service had taken place since the Commission field visits. The welfare directors reported that since the summer, no vendors have been dropped and they knew of no change in vendor practices.

[7] See footnote 9, page 23.

[8] In January, the Mississippi Commissioner of Public Welfare reported that certain segregated offices and practices in local offices have been eliminated through negotiation. A Negro child case worker has been transferred from an all-Negro State training school to work with an unsegregated case load in Hinds County.

Administrative Procedures of the State Agencies

State welfare departments had not involved the local county units in the process of securing compliance assurances from vendors. The approach of most State agencies to vendor compliance emphasized the signing of papers rather than the achievement of meaningful change in discriminatory practices. For example, the North Carolina State Welfare Department notified child care institutions in a letter that local departments "will not be able to place (children) in a children's home that does not sign a compliance statement." The department's letter did not indicate that nondiscrimination in admissions and operation was the objective of the assurance.[9]

In contrast, the Texas Welfare Department set a cut-off date for child care institutions which failed to comply with "nondiscriminatory requirements in extending care and service to clients." [10]

In no case did the Commission investigation find that local welfare directors had been instructed on the matter of referrals or assistance to Negro clients seeking service from vendors for the first time.

SUMMARY

Few opportunities for care or service previously denied to Negro welfare clients have in reality been opened to them as a result of Title VI. Some progress was noted in hospitals as early as this summer, but it was by no means even or general. Child care, nursing homes, private medical care, and training, where welfare departments have a major responsibility, are areas in which State and local directors had taken the least action. Most of the vendors of such service have not been told that they must change their practices to comply with the law. Emphasis has been upon the signing of papers.

[9] In January, the director of the North Carolina Department of Public Welfare said that in response to the State communications to vendor institutions, most of the 633 Homes for the Aged had signed assurances and that a number of these have now accepted whites and Negroes for the first time. An undetermined number have failed to sign assurances and local directors have been instructed not to use such homes. Several child care institutions have not signed, and their services are no longer used. He could not give a specific instance of a Negro child receiving care in a previously white institution.

[10] The Texas Welfare Department's Director of Program Administration reported in January 1966 that 60 percent of the vendors of care to children in the program had signed assurances. Other institutions were delaying signing in order to receive approval of boards of directors, or for similar formal reasons. The requirements of Title VI have been explained to the directors of these institutions. He reported that the State School for Delinquent Girls had received Negro girls for the first time; the Home for Dependent and Neglected Children had its first Negro children; Catholic homes in three cities and Boys City, Corpus Christi, and Boles Home, Quilin, had accepted Negro children for the first time. He did not have specific information on other changes in vendor practices.

VOCATIONAL REHABILITATION

With the aid of grants from the Vocational Rehabilitation Administration of DHEW, State governments provide medical and surgical care for handicapped adults, training and rehabilitation services, counseling, and placements in sheltered workshops or in private industry. Within the States such services may be located in a separate agency or may be part of a welfare department. Services to the blind are sometimes in a separate agency. As with the welfare departments, State vocational rehabilitation services provide counseling by State staff, but additional services are purchased from private physicians, hospitals, schools, and other institutions. Under DHEW procedures it has been the responsibility of the State agency to assure that those providing services to its clients comply with the nondiscriminatory requirements of Title VI.

Commission field staff reviews of State vocational rehabilitation programs identified wide differentials in the rate of progress toward achieving nondiscrimination in service to vocational rehabilitation clients.

The Texas Division of Vocational Rehabilitation assigned a top level official to coordinate its Title VI activities and to maintain a list indicating the services which were in compliance with the program. Area counselors, in personal visits, explained Title VI requirements to vendors and persuaded them to sign assurances of compliance. The counselors were responsible for monitoring the compliance program to assure that vendors remain in compliance.

The director of the Texas Division of Vocational Rehabilitation told Commission staff members that some institutions which refused to desegregate or admit Negroes were dropped from the program. The exclusion of these facilities did not adversely affect the quality of services provided by the Division, he said.

An interview with the San Antonio area supervisor of the Division of Vocational Rehabilitation confirmed that he had personally visited every vendor from whom he purchased services for clients. The visits were made to about 200 physicians, institutions, and schools. Some were reluctant to desegregate but finally yielded to "minimum persuasion," the supervisor reported. A tour of Goodwill Industries in Austin indicated that its workshop was desegregated.

The Mississippi Rehabilitation Division for the Blind, a vocational rehabilitation service that is an administrative part of the State Welfare Department, sought Title VI compliance in a manner similar to that of the Texas Division of Vocational Rehabilitation. The Mississippi agency instructed its staff to make periodic checks to guard against discriminatory practices in its programs. The memorandum of instruction was specific to the point of listing the types of racial practices forbidden and the requirement that courtesy titles be used in correspondence with clients. Staff members of the Division were made

responsible for assuring that the agency's services were furnished on a nondiscriminatory basis.[1]

Nonetheless, at the time of staff visits in September, Negroes and whites worked in separate departments at the Mississippi Industries for the Blind in Jackson, a State-operated institution. Before passage of the Civil Rights Act, the manager of the Jackson plant ordered the removal of racial signs from rest rooms and drinking facilities. After learning of requirements of Title VI early in 1965, he assigned a Negro woman to the all-white sewing department in the plant. The manager told Commission staff members his fear of opposition from the white employees disappeared immediately when the Negro worker was warmly received by her white co-workers.[2]

In striking contrast to Texas, the Louisiana Vocational Rehabilitation Program, at the end of August, had not informed its vendors of the requirement that services be provided on a nondiscriminatory basis. The Louisiana State agency had established no procedures for notifying vendors about Title VI requirements nor had it told its district staff about the requirements of the law. An interview with a public welfare official in Shreveport, who used the same vendors as did the Vocational Rehabilitation Program, indicated that schools, hospitals, and private physicians continue to practice racial discrimination and segregation in their buildings and offices.[3]

A physician in that city who treated patients under the Vocational Rehabilitation program said he had been told about the requirements of Title VI but had not been told when he would have to comply. This office had different days for white and Negro patients, as well as segregated waiting rooms.

In Selma, Alabama, the senior counselor said the waiting room of the Vocational Rehabilitation Service had been desegregated after passage of Title VI. He believed, however, that offices of vendor physicians were still segregated and that they needed more time to desegregate. Two companies previously used for on-the-job training had been dropped because they refused to sign an assurance. He also said that Selma Baptist Hospital, which did not admit Negroes and refused to sign an assurance, had been dropped from the program.

---

[1] In January 1966, the director of the Mississippi Rehabilitation Division for the Blind reported to the Commission staff that five of the 25 ophthalmologists in the State have refused to sign the new form which includes a nondiscrimination clause, and they are no longer used in the program. He had no knowledge of the extent to which general practitioners may have refused to sign the form, but the forms are being signed by some physicians. All but two of the colleges in Mississippi used in training blind persons have signed statements of nondiscrimination, and these two are no longer used by the Division. All of the six district offices which were in segregated buildings have been successful in having racial designations removed from public facilities, he reported.

[2] In January, the manager of the Mississippi Industries for the Blind reported that he had placed a second Negro woman in the sewing department in Jackson, and has also done this at another installation in Carthage. They are now recruiting Negro women for this department. The two snack bars, with the racial signs removed, continue to be patronized on a segregated basis.

[3] The Vocational Rehabilitation District Supervisor in Shreveport, Louisiana, reported in January that the requirements of the Civil Rights Act of 1964 had been explained to counselors at a state wide meeting in September 1965. A notice explaining the nondiscriminatory requirements of the Civil Rights Act had been prepared and would be given to vocational rehabilitation clients during their initial interviews, the Louisiana officials reported. They reported also that the State Welfare Department was handling the approach to physicians. Some physicians who had refused to participate in State welfare programs had asked to be dropped from the vocational rehabilitation program.

White vocational rehabilitation clients are now sent to Montgomery for hospitalization, with the Service paying transportation costs. The Vocational Rehabilitation Service, through its vendor physicians, sends only Negro patients to Good Samaritan Hospital.

The North Carolina State Vocational Rehabilitation Agency [4] was awaiting assurances of compliance from institutional vendors in mid-September. Only a training school and a hospital had refused to sign assurances and the State agency notified its local offices to refrain from referring clients to these two institutions. The director of the State Vocational Rehabilitation Agency reported that Title VI had achieved some desegregation of public and private hospitals, training institutions, and schools but he noted the extent of change would differ. The director volunteered the information that Negroes would be referred to previously all-white institutions, but no such referrals were known to have been made. Sheltered workshops had been established since the Civil Rights Act and operated on a desegregated basis because they were new programs.[5]

The State agency had not asked physicians to sign assurances. The director said that a substantial number of physicians had desegregated their offices. A local vocational rehabilitation office had been instructed not to use a white physician because a Negro client had complained of discriminatory treatment by the physician.[6]

The Cerebral Palsy Center in Raleigh, located in the rear of the segregated Wake County Memorial Hospital, since 1955 has provided service to Negroes and whites with a staff which includes a Negro speech therapist. Apart from three white families who withdrew their children from the program to avoid having them served by the Negro therapist, there has been no resistance to the desegregated program.

Officials of the North Carolina Commission for the Blind said they did not know if there was any racial segregation in the seven district offices housing rehabilitation counselors. The Commission for the Blind had not taken any action to secure assurances of compliance from its vendors, but had supplied its staff with lists of those who had signed assurances under other programs. The officials said there had been some changes in segregated practices of hospitals, training schools, and physicians used as vendors of service to their clients. They knew no specific instances of change, however. State officials did not know of any instance where Negroes were receiving service or training at an institution which had previously excluded them. A State-operated Rehabilitation Center for the blind had desegregated its dining and recreation rooms before the Civil Rights Act, according to the officials interviewed. Dormitories were desegregated after the passage of the law. Semi-private rooms would be assigned on a nonracial basis only

---

[4] This agency does not include services to the blind.

[5] An official of the North Carolina State Division of Rehabilitation reported to the Commission staff in January that some previously all-white training institutions had accepted Negro trainees and some Negro institutions had accepted white trainees. He could not be specific about the extent of such desegregation.

[6] In January, the Supervisor of Administrative Services of the North Carolina State Division of Rehabilitation said that the Division was not securing assurances from physicans but that the Division believed that physicians used in the program did not discriminate in services or facilities provided clients.

at the choice of the occupants, the officials said. Vending stands operated by the blind which had previously segregated their customers were reported to be desegregated. State officials said during the interview that they believed Title VI was a burden and complained that it hampered their program. They said they did not contemplate any compliance reviews.

In Tennessee the Division of Vocational Rehabilitation secured assurances of compliance from vendors throughout the State and forwarded the list to its local offices. Physicians were excluded from the effort. The Division's area director for western Tennessee said he had no knowledge of the actual practices of vendors nor did he have any responsibility for the practices of vendors serving vocational rehabilitation clients because the choice of a vendor was entirely up to the client.

The directors of the Western and Memphis regions of the Tennessee Division of Vocational Rehabilitation expressed the opinion that Title VI compliance had hurt their programs. While complaining that white business schools had been excluded from the program because of Title VI requirements, the two directors said they had not referred white clients to Negro business schools which had signed assurances and were willing to accept students regardless of race or color.

In every State the unavailability of vocational training for Negroes after physical rehabilitation appeared to be the most serious problem faced by the State vocational rehabilitation programs. In no State visited by Commission field teams could the State or local vocational rehabilitation personnel cite an instance where Negroes had been assigned to training facilities previously closed to members of their race.[7]

Physicians, schools, and hospitals supplying services to the Arkansas Vocational Rehabilitation Service were visited or contacted by mail by the State agency and asked to sign Title VI assurances of compliance. Some schools which refused to sign assurances were dropped as training centers. Some hospitals which refused to sign assurances were dropped from the vocational rehabilitation program. (An example was the Hospital for Crippled Adults, a private, all-white institution in Memphis, Tennessee.) While vendors who refused to sign assurances were dropped, the Commission investigation found no instance where vocational rehabilitation supervisors had checked the compliance posture of vendors who had signed assurances.

In Pine Bluff, Commission staff members visited a participating physician's office located in the same building as the Vocational Rehabilitation Service office and found a waiting room for "White Only" and a smaller room down the hallway for "Colored". A supervisor in the Service's Pine Bluff office told Commission staff members that clients who insisted upon being treated by a noncomplying physician probably could ignore a counselor who would advise against the use of a physician who segregated patients.

The Arkansas Vocational Rehabilitation Service maintains programs in the four totally segregated Arkansas State Training Schools, institutions for delinquent youth. The superintendent of the school for

---

[7] See footnote 5, page 27.

white boys in Pine Bluff told Commission staff members that he knew of no plan to desegregate the facilities. The continuation of rehabilitation services to this segregated school was not considered a Title VI problem by the staff of this vocational rehabilitation facility.

The director of a vocational rehabilitation center in Jacksonville, Florida, said he did not consider it his responsibility to determine whether or not institutions, schools, hospitals, and physicians were treating the center's clients on a nondiscriminatory basis. He secured assurances of compliance from all schools or training institutions used by the center except three which were dropped from the program. The center director said he relied upon the State Welfare Department to secure assurances from physicians and the State Board of Health to secure assurances from hospitals. He said he did not know if the physicians and hospitals providing services to his clients had signed assurances or not, and he did not know their actual practices.

Local offices of the Alabama Vocational Rehabilitation Department did not secure compliance assurances from vendors who served their clients but relied upon the State agency to furnish a list of vendors who signed assurances. Local personnel interviewed did not know how assurances were secured. The local district director in Mobile knew little about the extent of success in securing assurances from the vendors and was unfamiliar with requirements of the law. The district supervisor had referred no Negro clients to the State Vocational Training School although whites were referred. He did not know if vendors of service had actually changed their practices, although he said he had "heard" that Mobile General and Providence hospitals had desegregated. A number of physicians' offices were visited and no segregated waiting rooms were noted, although in some cases rest rooms were segregated. Physicians reported they had no information on the requirements of Title VI and that their offices had been desegregated prior to 1964. A large rehabilitation center maintained by the Mobile Rotary Club had been desegregated prior to 1964.

There was racial segregation in other parts of the Alabama vocational rehabilitation program. In Tuscaloosa, vocational rehabilitation State and local staff said that some white physicians who provide diagnostic and surgical services had eliminated segregated waiting rooms after signing Title VI assurances. Officials of the program reported that vendor compliance was checked by local staff members who made "stop-in" visits, usually once a month. Commission field team inspections, however, showed that vendor doctors continued to maintain segregated office facilities. Bryce Hospital, a State institution which maintained segregated facilities, continued to be served by the vocational rehabilitation program whereas a private business college in Tuscaloosa which had refused to accept Negro students had been dropped from the program.

SUMMARY

Title VI has opened up few new rehabilitation opportunities for Negroes in the States visited. Except for Texas, the State vocational

rehabilitation agencies have not made positive attempts to desegregate the services provided to their clients by insisting that vendors change their practices. Mainly, State agencies—again, Texas is the exception—have allowed the individual vendor to determine the method and pace of complying with Title VI. The Texas experience of making local personnel of State agencies responsible for securing assurances from vendors they use appears to have resulted in a high degree of compliance in that State and to have imbued the Texas Division of Vocational Rehabilitation with a sense of responsibility for Title VI implementation. Louisiana has made no attempt to secure assurances of compliance from its vendors and North Carolina lags behind other States in compliance activity.

Vocational rehabilitation, more than any other program covered by Title VI, relies upon the purchase of service from other institutions and individuals. Many vendors who provide medical care for the handicapped simultaneously provide care for persons under other federally assisted programs. Thus, there was potential for a coordinated approach to securing compliance of vendors who service vocational rehabilitation programs. Instead, individual administrators within and without the vocational rehabilitation service apply varying standards to vendors. The result has been minimal change at the local level, aside from Texas.

HEAD START

Project Head Start was funded as part of the Community Action Program by the Office of Economic Opportunity. During the summer of 1965, many communities spent a substantial portion of their total available funds on Head Start programs. Project Head Start was designed to provide eight weeks of classroom experience for pre-school children from low income and culturally deprived families so they would be on a more equitable educational basis with others of their age group when they started school. The program sought to improve the child's health, aid his emotional and social development, widen his horizons, increase his ability to get along with others, and develop in him and his family a responsible attitude toward society.[1]

All OEO-funded programs are subject to the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964, and an assurance of compliance must be submitted before funds are granted. In the case of Head Start programs, this meant that there could be no discrimination on the basis of race, color, or national origin in the selection of the staff of a Head Start center or of the children who would attend it. In view of these nondiscriminatory requirements it was reasonable to examine the extent to which this pioneer program was able to introduce new racial patterns into the educational systems in which it was operating as a pre-school adjunct.

The Commission survey of the Head Start program included 13 communities in eight Southern and border States, involving 70 projects in as many centers.[2] Of this total number, more than half, or 37, had an exclusively Negro enrollment and nine had an exclusively white enrollment. The remaining 24 projects showed varying degrees of integration among the student bodies.[3] Ten of these projects were integrated. Fourteen of the projects achieved only token integration. The following chart of project enrollments presents a city by city breakdown of these figures and indicates the degree of integration achieved by Project Head Start during the summer of 1965 in these cities.

---

[1] OEO publication, "Head Start: Child Development Program", pp. 19, 11.

[2] For a list of communities visited, see Table I. No visits were made by Commission staff to Head Start programs in Alabama. A report on those programs has been published by the Alabama Council on Human Relations, Inc., "Nondiscrimination Compliance in Fourteen Head Start Programs Operated by Alabama School Systems". Enrollment in most Alabama centers examined was not found to be integrated except in a token fashion.

Insufficient information was available on some facets of the programs in the three Wilmington projects and in four of the six Charleston projects visited by the Commission staff members. To insure consistency, these seven projects are not included in any of the charts or tables that appear throughout the chapter. These tables deal with 63 projects in 12 communities in eight States. If information on a specific facet of the program was available for any of these seven projects, it is footnoted in the table.

[3] Throughout this chapter, a project is considered integrated if the ratio of percent minority group in the project to percent of that racial group in the community served by that project was .5 or greater:

$$\frac{\text{percent minority in project}}{\text{percent that racial group in the community}} \geq .5$$

Not all classes within such a project were necessarily integrated.

Any project in which children of both races were enrolled, but in which the ratio of percent minority in the project to percent that racial group in the community served by the project was less than .5, was defined as a project with token integration.

Table I

Enrollment in Head Start Projects Surveyed, By Race

*Projects**	Number of children in Projects where there was:					
	Segregation		Token Integration		Integration	
	W	N	W	N	W	N
Arkansas						
Mississippi County	84	0			28	24
4 projects (29.7)	60	0			25	5
Pine Bluff-Jefferson County	0	54	8	67	27	7
15 projects (39.7)	0	78			8	11
	37	0				
	0	76				
	0	105				
	0	120				
	0	57				
	0	34				
	0	164				
	0	60				
	0	16				
	0	103				
Florida						
Jacksonville						
5 projects (41.2)	0	145	100	10		
			10	170		
			3	300		
			10	170		
Georgia						
Sumter County						
6 projects (52.8)	0	60				
	0	73				
	0	60				
	17	0				
	23	0				
	15	0				
Milledgeville						
2 projects (44.9)	0	135				
	0	92				
Macon						
8 projects (44.3)	0	60	42	2		
	0	60	43	2		
	0	45	43	2		
	0	60				
	0	45				
Louisiana						
Shreveport						
1 project (34.5)	0	58				
Mississippi						
Corinth						
2 projects (20.2)	60	0				
	0	150				

Table I—*Continued*

Enrollment in Head Start Projects Surveyed, By Race

Projects *	Number of children in Projects where there was: Segregation W	Segregation N	Token Integration W	Token Integration N	Integration W	Integration N
North Carolina [4]						
Craven County	0	80	22	2	11	18
9 projects (28.9)	0	21	2	38	10	10
	0	41				
	0	30				
	0	23				
Goldsboro	0	172			20	20
7 projects (41.2)	0	98			25	15
	0	88				
	30	0				
	17	0				
South Carolina [5]						
Charleston					22	17
2 projects (51.0)					28	50
Texas						
Corsicana			80	2		
2 projects (22.8)			1	143		
TOTAL						
Children	343	2463	364	908	204	177
Projects	41 [6]		12		10	

*Percent of nonwhite population in the community as of 1960 census is in parentheses following number of projects.

[4] In Wilmington, there was one project reported to be all-Negro, one reported to be predominantly white with 5 Negroes enrolled, and one reported to be predominantly Negro with 2 whites enrolled. More specific enrollment figures were not reported to Commission staff.

[5] There were four other projects in Charleston which were all-Negro. Exact enrollment breakdowns were not reported to Commission staff.

[6] Of this total, 32 projects were all-Negro and nine projects were all-white.

Enrollment figures do not tell the full story. In many cases, Head Start projects were taught by an integrated staff.[7] Staff integration was most common in the integrated projects, where nine of the 10 projects were taught by an integrated staff. Nine of the 12 projects with token integration had staff integration.[8] The all-Negro and all-white projects were less frequently accompanied by staff integration. Fifteen of the 32 all-Negro projects and seven of the nine all-white projects were taught only by teachers of the same race as the children.[9]

[7] A project staff was considered integrated if there were any Negro teachers or aides teaching with white teachers or aides. Note that this does not insure that *all classes* within the project were taught by an integrated staff.

[8] In addition, Wilmington's two programs with token integration had integrated staffs.

[9] In addition, Wilmington's all-Negro project was taught by an all-Negro staff. Two of Charleston's four all-Negro projects were taught by integrated staffs and two were taught by all-Negro staffs.

In many communities, the Community Action Board which sponsored and administered Head Start provided Negroes and whites their first opportunity to sit as a community group to discuss and solve common problems.

It is important to note that many of the communities with several all-Negro projects also had all-white projects. Children of both races were participating in the program but in racially segregated project centers. Sumter County, Georgia, for example, had 193 Negro children in three all-Negro projects and 55 white children in three all-white projects. The assignment of teaching staff followed racial lines. Macon, Georgia, had 270 Negro children in five Negro projects, but only six Negro children participated in the three projects serving 128 white children. These six Negro children were the only children in all of the city's projects who were taught by a teacher or aide of a race other than their own. Corinth, Mississippi, established two programs, one all-white and one all-Negro. One white aide served in the 150-child all-Negro project.

Projects in Corsicana, Texas, showed token integration. Two Negro children were in a project with 80 white children and one Mexican-American child was in the project for 143 Negro children. Staffs were integrated. In Jacksonville, Florida, 100 of the 123 white children in the program were enrolled in one predominantly white project. The other projects were predominantly or entirely Negro. However, transportation was provided, and all centers were staffed, on an integrated basis.

In Mississippi County, Arkansas, there were two all-white projects. However, the 29 Negro children who participated in the program were in integrated projects. A similar situation occurred in Charleston, South Carolina. Although there were four all-Negro projects, the 50 white children in the program attended integrated centers.

The Head Start programs in Goldsboro and in Craven County, North Carolina, showed some degree of integration tempered by a much greater degree of segregation. Participating in three all-Negro projects in Goldsboro were 358 of the 393 Negro children in the total program. Forty-seven white children, about half of those in the program, were in two all-white projects. The remaining 80 children were in two integrated projects, 20 whites and 20 Negroes in one, 25 whites and 15 Negroes in the other. Both projects were conducted in two predominantly white schools. School buses picked up both white and Negro children in outlying areas, providing the first integrated transportation. Field trips were integrated by combining children from different schools. With the exception of one white project, both Negro and white teachers and aides taught in all schools. The sponsors felt that the projects had afforded them the chance to take some significant steps in their community which would have a positive impact on race relations and future school desegregation.

Six of the Craven County programs were predominantly or all-Negro; one program was predominantly white. There were two integrated programs, one with 11 white and 18 Negro children and one with 10 white and 10 Negro children. The director of the program noted that this resulted because some Negro families took advantage

of the freedom of choice plan and entered their children in the school nearest their homes even though the school previously had been all-white. He believed that the desegregation of one elementary school, which was not in the Head Start program, had been eased by the example of Head Start during the summer.

In 1965, OEO allowed the sponsors of Head Start programs to meet the requirements of Title VI in one of two ways. The project centers could be set up to serve a particular geographic area; in this case, all children, regardless of race, would attend the center nearest their homes. The alternative was to adopt a plan, known as freedom of choice, under which parents could enter their child in the project of their preference. All programs visited by the Commission where there was more than one center in the community adopted the freedom of choice plan. Yet, except for the few isolated cases already described, such as Craven County, this plan failed to achieve integration within the projects.

The reason for the failure of freedom of choice plans to result in integration was not the subject of this study. Habit, fear, lack of adequate publicity, residential patterns may have been factors. However, one factor which emerged from the Commission study was that the racial composition of a project's enrollment was clearly related to its location. Head Start projects scheduled in centers ordinarily used in a segregated manner seldom had a biracial enrollment. The following table clearly shows this:

Table II

Project Enrollment	*Total No. of Projects*	*No. in Negro Schools*	*No. in White Schools*	*No. in Integrated Schools*
All Negro	32	29	3	0
All White	9	0	9	0
Token integration—Predominantly white	6	0	6	0
Token integration—Predominantly Negro	6	6	0	0
Integrated	10	0	3	7
TOTAL	63	35	21	7

Wilmington's all-Negro project was taught in a Negro school. Wilmington's predominantly Negro project was taught in a Negro school. Wilmington's predominantly white project was taught in a white school.

Charleston's four all-Negro projects were all taught in Negro schools.

No project in a Negro school was integrated in more than a token fashion. The few projects with integrated enrollments were in white or integrated schools. Even in the projects with token integration, the predominant group was the same group normally enrolled in the school. The utilization of normally segregated school buildings for Head Start projects resulted in a program conducted primarily within the segregated educational framework which is prevalent through-

out the South. Of the 4,459 children enrolled in the projects surveyed by the Commission, 4,078 were in projects in which there was either token integration or no integration at all.

Table III

PERCENTAGE OF HEAD START ENROLLEES BY TYPE OF PROJECT ATTENDED

Percent of Children	*Total*	*White*	*Negro*
In segregated projects	62.9	37.7	69.4
In token integrated projects	28.5	40.0	25.6
In integrated projects	8.5	22.4	5.0

Officials in the Office of Economic Opportunity who reviewed the information presented in this report, supplemented it by providing additional data from their own investigations of 409 projects in the eight States included in the Head Start survey of the Commission.

The data collected by OEO are not broken down in the same categories as that collected by the Commission. Under the definition adopted by OEO in its study, a project is "integrated" if there are children of both races enrolled in any proportion in the project. Thus, a project with one Negro child and 100 white children falls in the same category as a project with 50 Negro children and 50 white children. Using this definition then, 37.4 percent of the projects reported on by OEO in these States were integrated.

This was the same proportion as the combined total of integrated and token-integrated projects in the Commission survey. The chart below gives a State-by-State breakdown of OEO findings:

State	*No. of Projects*	*No. of Projects Integrated*	*Percent of Projects Integrated*
Arkansas	46	19	41
Florida	39	23	59
Georgia	93	21	23
Louisiana	48	9	19
Mississippi	47	8	17
North Carolina	60	39	65
South Carolina	38	8	21
Texas	38	26	68
TOTALS	409	153	37.4

SUMMARY

To the extent that Head Start was a new program in the field of education with an opportunity to demonstrate the possibility of integrated learning situations, its segregated structure in communities visited by the Commission staff resulted in a lost opportunity.

For the majority of the Negro children in Head Start programs surveyed by the Commission, the program meant that their first educational experience was in a segregated setting, similar to that of their older siblings. These pupils were housed in Negro schools, taught by Negro teachers, and surrounded by Negro classmates. Similarly, more than 75 percent of the white children participating in these projects had little or no contact with Negro children in the classroom.

COMPLIANCE ROLE OF FEDERAL AGENCIES

The success of Title VI of the Civil Rights Act in eliminating discrimination depends upon the systematic application of procedures necessary for its enforcement. These procedures include the initial securing of formal compliance agreements, the periodic review of programs which have agreed to comply, the investigation and resolution of complaints of continuing discrimination, and the application of the ultimate enforcement sanction—termination of Federal funds. If compliance is to be uniform and complete, Federal agencies which implement and enforce Title VI must take the responsibility for applying these four procedures consistently. If the responsibility is left to the individual States and local agencies, compliance probably will be erratic, as evidenced by the Commission investigation.

As reported in earlier chapters, there has been some progress toward desegregation of physical facilities. At the same time, however, there is substantial continuing noncompliance with Title VI. Compliance varies from State to State, county to county. This fact suggests that coordination by Federal agencies has been neither consistent, continuing, nor uniform.

The Period of Formal Compliance

During the half year following passage of the Civil Rights Act, Federal officials drafted regulations applicable to the various programs and discussed the regulations with State officials. The regulations, issued in December 1964 and in January 1965, required prompt compliance, although some flexibility was allowed to meet special needs and problems.[1]

Interpretation of the regulations and approval of plans submitted by State agencies occupied the staffs of the Federal agencies until the summer of 1965. More than 100,000 assurances of compliance were submitted by institutions which had received or expected to receive Federal assistance. Each State program which received Federal financial assistance was furnished some guidance in submitting a statement of compliance with Title VI, and, as these plans were received, they were reviewed for legal and factual sufficiency. The purpose of plans submitted by the State under the regulations was to identify the kinds of noncomplying practices existing in their programs and to set forth the method and timetable by which they would be eliminated. Such a catalog of noncompliance was intended to furnish an initial basis for review so Federal agencies could determine the extent of compliance with the law.

The regulations required the State agencies to secure compliance from thousands of institutions and individuals providing service for a

[1] In some cases, deadlines of six months or a year reflected the length of leases made by the Government for space in buildings with segregated facilities.

fee to clients of federally assisted programs. The States also were responsible for ascertaining that institutions and individual vendors were currently in compliance with the law.

The Acceptance of Statements of Compliance

Although emphasis had been on achieving maximum consistency in the drafting of regulations under Title VI, DHEW agencies accepted State agency plans for the elimination of noncompliance which were widely divergent in important aspects. Some States not only listed instances of noncompliance, but set dates and plans for their elimination. Other States, with similar problems, neither identified noncompliance in detail nor explained the methods which would be used to eliminate discrimination. Some plans contained target dates for compliance in a few areas, but not in others. In several instances, DHEW rejected inadequate plans and required that the plans be resubmitted. In some cases, the plan eventually accepted provided more detail of noncompliance and of plans for elimination of discriminatory practices. In several programs involving the administration of State hospitals, the target date for compliance originally submitted by State agencies was as long as two years away. These plans were rejected. In January 1966, the Alabama Health Department, the Alabama mental health program, and Virginia's mental health program had not submitted acceptable plans to eliminate discrimination. Both States operated segregated mental hospital systems.[2]

Inconsistencies developed in important areas of enforcement. Within the same State, different programs placed different responsibilities upon administrators at the local or county level where the greatest impact of Title VI would be felt. Within the same program, Federal agencies approved significant variations in the plans for compliance from State to State, with the result that some State directors of programs were far ahead in compliance, while no action had been taken in a nearby State. The result was scattered and uneven compliance even at the simplest level of desegregation of facilities. Hence, there were inconsistencies in approach to implementation of the regulations.

The Georgia State Health Department, for example, required each county board of health to sign an assurance of compliance,[3] while the Welfare Department did not require such assurances of county boards of welfare. Each of these boards is an independent citizens' group administering a federally assisted State program.

In Texas, the State Health Department required an assurance from the county health officer, but the Welfare Department did not require one from the local welfare director. Health and welfare directors are both county employees, responsible to independent citizen boards.

---

[2] A DHEW official explained that the Alabama mental hospital system was in a department which was undergoing reorganization and that this accounted in part for the delay in submitting an acceptable statement of compliance. It should be noted that the Georgia State mental hospital accomplished its desegregation at the same time as it carried out an extensive reorganization of service.

[3] There was no evidence that State officials made any attempt to determine the validity of these assurances through on-site compliance reviews.

The local vocational rehabilitation programs of States visited by the Commission staff showed the widest variation of compliance activity and understanding of the requirements of Title VI. As noted earlier, the State director of vocational rehabilitation in Texas had required his local and area staff to visit all institutions and physicians with whom they worked and to get them to eliminate discriminatory practices in services rendered to clients. Texas personnel visited were well informed about the practices of vendors and the extent of compliance in their area. They had used persuasion where necessary to secure compliance. In no other State visited had the State director assigned to the local vocational rehabilitation counselors the responsibility for securing the signing of assurances and the actual change in nondiscriminatory practices. In other States, except for the Mississippi program for the blind, local vocational rehabilitation personnel interviewed were awaiting action by other programs, were relying upon lists circulated by the State office, and had failed to make even the most rudimentary inspections to determine whether the signing of an assurance had resulted in elimination of a discriminatory practice.

All programs failed to adequately identify the need to secure compliance from physicians who provided services to program beneficiaries. The programs also failed to provide specific plans to eliminate discriminatory practices. Methods used by the States to get physicians to comply with the law varied from requiring each physician to sign a nondiscriminatory statement when he was paid for his professional services to merely sending physicians a notice that the agency would assume they were complying with the law as long as they continue to accept payment for services provided beneficiaries.

In several instances it was noted that stricter standards for the elimination of discrimination were applied to private institutions than to public institutions.[4] Thus, while local vocational rehabilitation programs stopped using segregated private schools for training of clients, they continued to maintain units in segregated public institutions.[5] Other instances were noted in which welfare programs made referrals to State hospitals which had discriminatory practices but dropped from their program private hospitals with the same patterns of discrimination. Vocational rehabilitation and welfare officials in Washington were aware of this inconsistency but did not have any proposals to eliminate it.

Compliance Review

By July 1965, a survey by the President's Council on Equal Opportunity indicated that most agencies had completed the paper work

[4] An alternative course of enforcement against publicly owned segregated facilities would be an action under Title III of the Civil Rights Act of 1964.

[5] In the case of institutions such as the Arkansas State Training School, it was explained by Washington officials of the Vocational Rehabilitation Administration that such a school is under the jurisdiction of the Office of Education which has established a later date for compliance with the law than was set by VRA.

required by the regulations, but no agency had instituted a systematic review of its programs to determine the extent of noncompliance and to correct the situation. This remained true in January 1966.[6]

Where State agencies had filed plans acceptable to DHEW, the Department has not checked to determine whether the formal requirements of the plan, e.g., for the submission of progress reports, were being met.[7]

The compliance plan filed by Virginia in July 1965 with the Vocational Rehabilitation Administration called for a report every three months on the elimination of noncomplying practices. No such report has been received and the Federal officials in charge of compliance were unaware of the requirement that such reports be filed.

No State welfare agency which filed statements of compliance containing items of noncompliance was required to submit reports on progress in eliminating noncompliance,[8] and no information is available in Washington to determine the extent to which noncomplying practices exist or the steps which have been taken to eliminate them.

Although the North Carolina plan was accepted "with the understanding that all areas of noncompliance will be corrected by September 1, 1965",[9] the Welfare Administration in Washington had neither received nor requested, since September 1965, information on the compliance of hospitals, day care or child care centers or nursing homes. The regional office knew only the number of assurances that had been submitted. No compliance review had been undertaken and no report on the elimination of discriminatory practices had been received. The Virginia plan set dates for the elimination of segregation in public facilities. October 1, 1965, was set for desegregation of offices under control of the program and January 1, 1966, was set for desegregation in buildings in which the agency leased space. If desegregation was not accomplished, a deadline was set for moving from the building. After October 1965, no reports were received or requested by the Welfare Administration on the status of desegregation in local welfare offices. New cases were to be assigned to case workers without regard to race after November 1, 1965, but the Welfare Administration sought no information on the matter after November 1. Segregation and discrimination in other agencies from which services were purchased was a noncomplying practice noted by the State but no date was set for compliance. No report on this was requested or received. In regard to physicians, the Virginia State plan said merely there was "no known discrimination" by physicians.

---

[6] For example, the PHS does not know the state of compliance in the majority of hospitals which have signed assurances with DHEW. A checklist for compliance which DHEW planned to send to all hospitals received Bureau of the Budget approval and was printed in the Fall of 1965 but was never used.

[7] Except as otherwise noted, all statements about the extent of Federal involvement in compliance were made as of January 1966.

[8] At an early stage DHEW instructed its agency administrators to secure reports from State agencies. (Memorandum of March 1, 1965.)

[9] DHEW, Welfare Administration, State plan files.

In Louisiana the State plan of the department of public welfare stipulated:

> We will make periodic reports to DHEW regarding the extent of compliance or noncompliance by hospitals to which we make vendor payments. . . . We will report in detail on those requesting an extension of time and setting forth their reasons and will stop payments to those whose reply is that they cannot or will not comply with the Civil Rights Act. (DHEW, Welfare Administration, State Plan File, Louisiana State Plan, August 9, 1965).

DHEW has neither requested nor received reports on hospital desegregation or availability of nursing homes which were also the subject of consideration in the State plan.

Under the statements of compliance accepted by the various agencies of DHEW, State agencies were responsible for securing assurances of compliance from vendors of service. In the States visited, one or more State agencies had issued lists of vendors who had signed, and, in some cases, vendors who had refused to sign. These lists were furnished to State and local staff of covered programs. The lists were valuable as an indication of the scope of Title VI coverage in a State, as well as an index of initial formal compliance with the law. The Public Health Service, the Vocational Rehabilitation Administration, and the Welfare Administration had not asked for or received lists of vendors from State programs. While regional offices of the Department were able to provide the number of assurances received or refused in the States in their region, they had no more specific data on vendors.

This lack of knowledge of the degree of compliance was present in other programs investigated by the Commission staff. In January 1966, neither the Children's Bureau nor the Public Health Service had information on the number of segregated clinics or clinics which served only one race. The statements accepted by the agencies had not identified the problems of compliance in specific terms.

Field Inspections and Complaint Investigations

Although DHEW agencies are uninformed about the extent and efficiency of compliance activities undertaken by State agencies, they have made no attempt to conduct their own systematic field reviews. In contrast, the Office of Economic Opportunity has built into Operation Head Start a plan which provides for compliance reporting and field evaluation. Project Head Start was the only program studied in which administrators were informed about what had happened in response to their nondiscrimination requirements. Although there was considerable latitude in its definition of integration, OEO's study showed that the guidelines for Head Start's first year of operation were not adequate to achieve integration in many areas. The knowledge which OEO secured from its systematic compliance review and re-

porting system enabled it to revise its guidelines to meet the problem.[10]

The DHEW agencies' compliance activity occurred only in response to complaints.[11] In the absence of complaints, agencies had no knowledge of the extent of change necessary for compliance or the rate at which change was being undertaken. Thus, where Federal responsibility for compliance has depended upon investigation of complaints, rigorous investigation and prompt action upon the findings is particularly important.

The Public Health Service has used the complaint process to check compliance of hospitals covered by the Civil Rights Act. Yet, DHEW was slow in taking corrective action in the case of the few hospitals in the Commission's survey which the Department had found to be in violation of the law. James Walker Memorial Hospital in Wilmington, North Carolina, had been found in noncompliance a number of months before the Commission inspection. The administrator gave no indication that he intended to comply with the law even after meeting with members of DHEW's regional staff. After the Commission reported the findings of its investigation of the hospital, a team of DHEW officials from the Washington and regional offices met with the administrator, members of the hospital board, and city officials and compliance was achieved. DHEW had taken no action against Confederate Memorial Hospital in Shreveport, Louisiana, despite the fact that the institution refused even to permit PHS officials to inspect the facility.

Some hospital administrators who had been found in noncompliance said they needed Federal officials to help them interpret the law to members of their boards. Investigation of some complaints by DHEW noted, as did the Commission's survey, that a principal deterrent to compliance was the fact that other hospitals in the community had not complied with the law. The prompt response of some hospitals to the DHEW return visits after Commission findings were reported to the Department indicated a need for more effective enforcement procedures. Moreover, discovery by Commission staff of segregation in hospitals which had previously been found in compliance by DHEW investigators raises questions about the standards of the investigation of complaints and reviews of compliance.

---

[10] The new guidelines for Head Start programs provide that each project will serve a distinct, compact area, and all poor children living in that area will be attending that center. Any plan which departs from this, such as freedom of choice, will be accepted only if it is demonstrated to OEO that it will result in more project integration, not less. (U.S. Office of Economic Opportunity, "Head Start: Child Development Programs," p. 16). In the future, Child Development programs, incorporating the principles of Head Start, will be year-round programs with permanent staff and sponsorship. The compliance procedures provided in Title VI and its regulations will be suitable for application to such a program, as they were not for a short term program.

[11] An early DHEW memorandum to agency administrators stated: "The exact Federal steps for checking on compliance have not yet been determined. However, it will be a positive program. Primary reliance will not be placed on complaints." (March 1, 1965)

Enforcement Proceedings

Title VI provides for hearings which may result in termination of funds in instances where negotiation fails to correct violations of the law. The hearings may result when a State agency fails to file the required documents or an acceptable statement of compliance after protracted negotiations or when discriminatory practices continue in violation of a statement of compliance or assurance which has been accepted. A State agency is required to discontinue using vendors when they do not comply with the law.

The Alabama Department of Pensions and Security, which administers the State's welfare program, has refused to file a statement of compliance and the program continues to be operated outside the framework of the regulations. Enforcement proceedings began with a hearing on October 21, 1965. There has been no announcement of a decision resulting from the hearing.

Three State programs—the health and mental health programs in Alabama and the mental health program in Virginia—have submitted inadequate statements of compliance which allow for the continuance of discriminatory practices for the next several years. These plans have been rejected and negotiations continue while similar programs in other States have begun the process of desegregation. There has been no move to call up these State programs for a hearing.[12]

No other enforcement proceedings have been instituted for failure to comply with an assurance or a plan.

Departmental Reorganization

In January 1966, DHEW reorganized its compliance program in an effort to strengthen its activities in this area. The program was placed under the supervision of a Special Assistant to the Secretary of Health, Education, and Welfare.

---

[12] Complaints against 135 hospitals have been found to be valid; some notifications of noncompliance have been outstanding for many months. Many of the hospitals against which complaints have been filed are covered by Title VI only as vendors to State programs. DHEW has not required State programs to discontinue using vendors against whom valid complaints are outstanding and it is not known how many are still being used. Another 100 complaints are reported by DHEW as "resolved", a category which officials defined as meaning that the hospital is in compliance and has been removed from the complaint list. New grants are not made to hospitals against which complaints are pending and PHS investigates compliance among applicants for new Hill-Burton grants.

FINDINGS

After surveying local health and welfare programs in more than 40 Southern and border communities in the summer and fall of 1965, the U.S. Commission on Civil Rights finds that:

1. Written agreements to comply with Title VI of the Civil Rights Act of 1964 have been secured from most federally assisted programs. There has also been progress in the elimination of the most overt forms of segregation such as separate hospital wings and segregated waiting rooms and public facilities. There have been a few instances of rapid and complete hospital desegregation.

2. There continues to be widespread segregation or exclusion of Negroes in federally assisted programs at the State and local level in the areas visited:

   a. Some State operated hospitals and training facilities remain segregated.
   b. A number of local hospitals have eliminated separate Negro wings or buildings in response to the requirements of the Civil Rights Act, but in most hospitals Negro patients are still assigned to wards or rooms occupied only by Negroes.
   c. Negroes continue to be excluded from many child care institutions, nursing homes, and training facilities which are providing service for a fee to white beneficiaries of federally assisted programs. Local officials of some federally assisted programs are not referring Negroes to services previously denied them.
   d. Certain federally assisted local health programs are racially exclusive or segregated.
   e. Some physicians who are providing service to beneficiaries of federally assisted programs continue to segregate patients in their offices and to make racial distinctions in the referral of patients to hospitals.
   f. Where dual facilities were maintained, the removal of racial designations has not, in the absence of other action by administrators, eliminated segregation.
   g. The majority of children in Operation Head Start were enrolled in segregated projects located in segregated schools and taught by teachers of their race.

3. The Department of Health, Education, and Welfare, after drafting and issuing the regulations and formal documents required thereunder, has failed to take the steps necessary to achieve compliance. For example:

   a. Uniform and consistent standards have not been applied to State programs.
   b. States have not been required to report on the steps they have taken to achieve compliance.

c. Except for complaint investigations, field inspections have not been undertaken to ascertain the extent of noncompliance in continuing State programs.
d. No enforcement action has been taken even where negotiations have not resulted in the elimination of violations of the law.

4. The failure to adopt adequate review and compliance procedures has made it impossible for DHEW to know whether discrimination is actually being eliminated.

5. The Department of Health, Education, and Welfare has not provided State and local directors and administrators of federally assisted programs with the information, support, and leadership necessary to facilitate compliance under Title VI of the Civil Rights Act of 1964.

RECOMMENDATIONS

The Commission believes that the Department of Health, Education, and Welfare should take the following steps for effective implementation of Title VI of the Civil Rights Act of 1964:

1. **Proceed immediately to apply sanctions where negotiations have failed to correct violations of Title VI.**

2. **Conduct immediate surveys and thorough field inspections to determine the extent to which discrimination continues to exist in federally assisted programs.** These reviews should include all programs in a community, with uniform deadlines fixed for full compliance. Special attention should be given to the compliance of vendors of State programs.

3. **Establish for its programs, the affirmative goals of actual participation on a desegregated basis in all the benefits offered.**

4. **Institute regular reporting systems and program evaluation sufficient to identify areas of noncompliance and racial differentials in benefits received in each program and facility.**

APPENDIX A

Following is a list of agencies and departments which have issued regulations effectuating Title VI of the Civil Rights Act of 1964.

Agency	Citation to the Code of Federal Regulations
Agency for International Development	22 CFR, Part 209
Agriculture, Department of	7 CFR, Part 15
Atomic Energy Commission	10 CFR, Part 4
Civil Aeronautics Board	14 CFR, Part 379
Commerce, Department of	15 CFR, Part 8
Defense, Department of	32 CFR, Part 300
Federal Aviation Agency	14 CFR, Part 15
General Services Administration	41 CFR, Subpart 101-6.2
Health, Education, and Welfare, Department of	45 CFR, Part 80
Housing and Urban Development, Department of	24 CFR, Part I
Interior, Department of	43 CFR, Part 17
Labor, Department of	29 CFR, Part 31
National Aeronautics and Space Administration	14 CFR, Part 1250
National Science Foundation	45 CFR, Part 611
Office of Economic Opportunity	45 CFR, Part 1010
Office of Emergency Planning	32A CFR, OEP Reg. 5
Small Business Administration	13 CFR, Part 112
State, Department of	22 CFR, Part 141
Tennessee Valley Authority	18 CFR, Part 302
Treasury, Department of	33 CFR, Part 24
Veterans Administration	38 CFR, Part 18

APPENDIX B

Extract from
State of Georgia
Department of Public Health

Report filed pursuant to Title VI of Civil Rights Act of 1964 (signed by John H. Venable, M.D.) Dated April 22, 1965

. . . . . .

2. *Milledgeville State Hospital*

This is presently the only state institution for the treatment of the mentally ill in Georgia. The institution accepts all varieties of patients including the criminally insane; it has approximately 12,000 beds and consistently maintains a full patient load. It is organized under the Division of Mental Health, Georgia Department of Public Health.

a. Grant Program: State funds only except the following special projects which are *pending* and require HEW Form 441 which has previously been submitted to the Department of Health, Education and Welfare:

Hospital Improvement Project
In-Service Training Project
Test for Tranquilizers Project

b. Geographic Area and Political Subdivision: Milledgeville, Georgia
Baldwin County

c. Prohibited Practices and Extent of Noncompliance: This institution has historically had separate facilities for white and Negro patients. In order to fully comply with Section 601 of the Civil Rights Act of 1964 segregated facilities, programs, or services such as the following will have to be integrated: classrooms of the Educational Department, State Domiciliary (Veterans) Home, General Medical and Surgical Building, Outpatient Department, Yarbrough Rehabilitation Building, Occupational-Music- and Recreational Therapy Departments, Central Library, Chapels, Remotivation Division and all other activity programs, Children's Building, Adolescent Division, and the individual treatment and housing units which contain admission services, intensive treatment divisions, infirmaries, and the prolonged treatment services.

d. Steps and Timing for Compliance:

The following plans and timing for full compliance with the Civil Rights Act of 1964 represent a maximum amount of time estimated to accomplish the goals and yet disturb to a minimum

the operation of the hospital. It is hoped that compliance can be achieved in lesser time than the schedule indicates. The major consideration which must be given in the integration of so large an institution is the best interest of the mentally ill patients and an effort to program changes in such a way as to minimize the disturbance of patients.

(1) Integration will be established in the State Domiciliary Building (Veterans) and will then be extended to the classrooms of the Education Department, General Medical and Surgical Building, Out-patient Department and the Yarbrough Rehabilitation Building. Upon completion of this project there will be no distinction made on the grounds of race, color, or national origin. Begin: Immediately. Completion: June 15, 1965.

Also, beginning immediately, efforts will be made to establish centralized programs for the mentally retarded, alcoholic, tuberculous, senile, and criminally insane on an integrated basis. The completion date of this phase will be on or before the final integration of the nine units of the hospital described in (4) below.

Beginning immediately, employee living quarters will be integrated as vacancies occur according to the employee's position on a non-discriminatory waiting list.

(2) The next phase will integrate the Occupational, Music Therapy and Recreational Departments, Central Library, Chapels, Remotivation Division and all other activity programs. Upon completion of this phase, there will be no distinction made on the grounds of race, color, or national origin. Begin: Immediately. Completion: Completed as of the revision of this plan on April 22, 1965.

(3) The next phase will be to integrate the Children's Building and Adolescent Division. Upon completion of this phase there will be no distinction made on the grounds of race, color, or national origin. Begin: July 15, 1965. Completion: August 15, 1965.

(4) The institution is divided into nine separate units or individual hospitals. The hospital is presently in the process of reassigning patients between units so that a particular unit will house patients from a designated geographical area of the state. Integration has begun with the transfer of patients and employees from the wards of two units at a time. The integration of patients and employees superimposed on the transfer of patients to geographical units is obviously time consuming in a mental institution with 12,000 patients and over 3,000 employees. Upon completion of this phase the entire hospital will be in compliance with Title VI of the Civil Rights Act of 1964. Begin: Already in process. Completion: November 15, 1965.

(5) The implementation of the phases of this program described above will also include the transfer of certain employees where appropriate. This transfer will be made simultaneously with the integration of patients. The hospital has over 3,000 employees. Employees will be assigned in such a manner so as to prevent distinction on the grounds of race, color or national origin.

U.S. GOVERNMENT PRINTING OFFICE : 1966 OF—206-438