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AN ABSTRACT OF THE THESIS of Susan Peters for the Master of Science in Psychology presented July 26, 1977.

Title: The Mentally Retarded's Right to Meaningful Treatment:
A Review of Legal and Psychological Literature.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

Pamela Osborne Munter, Chair

Gerald D. Guthrie

Hugo M. Maynard

Keith H. Larson, Graduate Representative

A review of legal provisions and practices and current psychological theory and research concerning the mentally retarded indicated inconsistencies between the law and current theory. Laws have been based on archaic models which fail to consider the heterogeneity of those classified as retarded and their potential for development and training. Retardation professionals have agreed that normalization of institutionalized mentally retarded and mainstreaming in education are

preferable principles. Research comparing the effects of community living and institutionalization and effects of special and integrated classes was sparse and inconclusive; the major thrust of research has been on the 4% of all mentally retarded who are institutionalized. Legal attitudes toward the retarded have changed only in the area of institutionalization, particularly guaranteeing due process during commitment. Litigation has been involved in habilitation and the least restrictive alternative, the legal counterparts to normalization. Courts have relied on constitutional, statutory, tort and contract theories and deal mainly with the institutionalized retarded. Laws imposed on the non-institutionalized retarded have demonstrated a particularly restrictive parens patriae attitude. Cases have been inconsistent, resulting in no clear standard as yet. A more recent trend has been on legislation which is more consistent than litigation. Recommendations based on theory and research and status of present laws included the following: 1) more emphasis on research of retarded in the community, on community living versus institutionalization, and on special education versus integrated, mainstreamed classes; 2) development of national standards incorporating the principle of normalization and a developmental approach to services; re-evaluation and amendment of present laws to expand the rights of non-institutionalized and 4) adoption of legislation giving all mentally retarded a right to habilitation, establishing a committee to develop and revise minimum

standards, creation of a monitoring team to periodically review each patient's treatment plan and formulation of a manual setting forth minimum treatment levels.

THE MENTALLY RETARDED'S RIGHT TO
MEANINGFUL TREATMENT: A REVIEW OF
LEGAL AND PSYCHOLOGICAL LITERATURE

by

SUSAN PETERS

A thesis submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE
in
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Portland State University
1977

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TABLE OF CONTENTS

	PAGE
INTRODUCTION.....	1
CHAPTER	
I HISTORY AND CLASSIFICATION.....	6
Legal Terminology.....	15
Public and Private Organizations.....	19
Psychological Terminology.....	21
Summary.....	27
II CURRENT CONCEPTS IN MENTAL RETARDATION.....	30
Archaic Models.....	32
Present Conditions.....	34
Emerging Principles.....	36
Developmental Model	
Normalization	
Deinstitutionalization	
Mainstreaming	
Applications.....	41
Sweden	
Nebraska	
Oregon	
Research.....	49
Etiology	
Lab Research	
Vocational and Educational Setting	
Treatment Facilities	
Evaluation.....	63
Summary.....	69

CHAPTER	PAGE
III LAW AND THE MENTALLY RETARDED; AN OVERVIEW.....	71
Civil Commitment.....	74
Legal Incompetency.....	77
Guardianship.....	79
Criminal Law.....	83
Restrictions in the Community.....	85
Restrictions on Personal Rights.....	91
Summary.....	99
IV THE RIGHT TO TREATMENT.....	101
Bases for the Right.....	102
Fourteenth Amendment	
Due Process	
Equal Protection	
Eighth Amendment	
Thirteenth Amendment	
Statutory Bases	
Negligence and Breach of contract	
Justiciability.....	130
Summary.....	132
V CONCLUSION.....	134
Deinstitutionalization.....	138
Least Restrictive Alternative.....	142
Litigation vs. Legislation.....	143
Recommendations.....	147
BIBLIOGRAPHY.....	149

INTRODUCTION

Recently the trend of the law towards involvement in the area of mental retardation has resulted in the courts' evaluating and specifying treatment for the mentally retarded. In a landmark case, Wyatt v. Stickney,¹ establishing judicial review of the question of adequacy of treatment, Judge Johnson said:

Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense...The purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment...In the context of the right to appropriate care...no viable distinction can be made between the mentally ill and the mentally retarded. Persons committed to mental health facilities shall be afforded adequate treatment./Emphasis added./

"Shall" is a strong word, rarely used in psychological literature but frequently in the law. It is difficult to

¹325 F.Supp. 781 (M.D. Ala. N.D. 1971) quoting from Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 281 F.2d 943, 950 (1960). (Wyatt was the first case to hold that both the mentally ill and the mentally retarded were entitled to adequate treatment. A mentally retarded patient's right to due process and equal protection under the Fourteenth Amendment to the U.S. Constitution is violated when the state confines a patient on the "altruistic theory" that he must receive treatment and then fails to provide it.)

determine to what extent "shalls" can be legislated or judicially determined where human conditions are involved.

Judge David Bazelon, author of an early court decision ruling that the mentally disabled have a right to treatment,² calls for an interdisciplinary approach to the problem of appropriate treatment.³ Professionals in the field of retardation--attorneys,⁴ legislators, judges, psychologists, social workers and those in special education--are concerned with the relationship between new concepts in the area of mental retardation and the current legal controversies.

²Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1967)
(Failure of a state mental health facility to provide treatment to a person involuntarily committed was contrary to the requirements of the 1964 Hospitalization of the Mentally Ill Act, D.C. Code Ann. §21-501 (1966) mandating treatment for "persons hospitalized in a public hospital for mental illness". His opinion and a concurring opinion by Judge Fahy suggest that even without this statutory mandate, a person has a constitutional right to adequate treatment under the due process and equal protection clauses of the Fourteenth Amendment of the U.S. Constitution or the prohibition against cruel and unusual punishment of the Eighth Amendment of the U.S. Constitution.

³
Bazelon, D., The Mental Disability Law Reporter, 1 (June-July, 1976) I. The journal is a publication of the American Bar Association Commission on the Mentally Disabled. It reviews case law, legislation and regulations, and articles. It also lists major works on mental disability law and the activities of the ABA Commission. It is designed for attorneys and judges as well as all persons working in and affected by the mental disability system.

⁴
The American Bar Association, in establishing the Commission on the Mentally Disabled, recommended that state associations follow suit. In 1976 the Oregon Board of Bar Governors established an Oregon Committee for the Rights of the Mentally Disabled, which began meeting in January, 1977.

Habilitation for the mentally retarded and evaluation of the effectiveness of the effort, traditionally the domain of psychology, is now an established justiciable⁵ area. Mental retardation is a theoretical and practical issue for the law and psychology, from definition to treatment.

Definitions and classification of the mentally retarded have developed with legal, medical, educational and psychological facets.⁶ Treatment of the mentally retarded is both the province of psychologists and of the courts. Also adequacy or effectiveness of treatment, always a concern of clinical psychologists and psychological research, is a justiciable question for which the courts are seeking evaluation measures. Communication between the two professions as both consider mental retardation will facilitate the goals of both--serving the best interests of the mentally retarded citizen.

5

Justiciable: a controversy appropriate for judicial review. The right to treatment was first addressed in a legal position paper by Birnbaum, The Right to Treatment, American Bar Association Journal, 1960, 46, 499 and has been recognized in landmark cases, Rouse v. Cameron (summarized in note 2) and Wyatt v. Stickney (summarized in note 1).

6

There are considerable problems in the definition and classification of mental retardation seen by psychology and the law. New trends in psychology are away from classification. The trend in the law is to classify. The problem, psychologically and legally, of labeling is an issue in itself, not to be reviewed in this paper but briefly discussed in Chapter III. The interested reader may consult the growing literature on this subject. See Robinson, N.M. & Robinson, H.B., The Mentally Retarded Child: A Psychological Approach. New York: McGraw-Hill, 1976.

The purpose of this thesis is to review the legal right to treatment⁷ and current theory regarding treatment of the mentally retarded and discuss implications for mental retardation considering current legal trends and psychological theory.

⁷ Different legal rubrics have been used in several cases--"protection from harm," "right to treatment" and "need for care" and right to "normalization and habilitation." There have been significant judicial decisions in the field recently. "Habilitation" is a more inclusive term meaning the process by which the staff of the institution assist the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment. Wyatt v. Stickney, supra, App. A. In New York State Association for Retarded Children, Inc. v. Carey, 393 F.Supp. 715, 718 (E.D. N.Y. 1975) Judge Judd notes that the consent judgment reflects the "fact that protection from harm requires relief more extensive than this court originally contemplated, because harm can result not only from neglect but from conditions which cause regression or which prevent development of an individual's capabilities." In Donaldson v. O'Connor, 493 F.2d 507, 527 (5th Cir. 1974) vacated 422 U.S. 957 (1975), the court held that "where a nondangerous patient is involuntarily civilly committed to a state mental hospital such a patient has a constitutional right to such treatment as will help him to be cured or to improve his mental condition". In Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) the court upheld the lower court rulings that there is a "right to treatment" for civilly committed mentally retarded persons. It held that persons in institutions for the mentally handicapped were entitled to constitutional minimum quality of care and treatment even if their confinement was justified only by the "need for care," 503 F.2d 1313. See also Welsh v. Likens, 373 F.Supp. 487 (D.Minn. 1974); Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974).

Five areas are covered;

1) a review of legal and psychological history, definitions and classifications of mental retardation;

2) current theory, applications, research and evaluation methods regarding treatment for the mentally retarded;

3) an overview of commitment and civil rights laws as they affect habilitation of mentally retarded;

4) the legal right to adequate treatment/habilitation-- a review of the constitutional and other legal bases for treatment, and judicial involvement in evaluating adequacy; and

5) conclusions, including: a) review of the legal provisions for treatment in Oregon; b) implications of judicial and legislative developments and current theory for Oregon judges, legislatures and mental retardation specialists; and c) recommendations.

CHAPTER I

HISTORY AND CLASSIFICATION

Throughout recorded history the condition of mental retardation has persisted. Society has labeled various characteristics from simply acting "differently" to I.Q. scores as evidencing mental retardation. Similarly, society's attitudes toward the mentally retarded have also varied from ostracism, condemnation and even death to parental affection. Laws and treatment have swung from extremes of institutionalization to deinstitutionalization for all retarded. Vestiges of archaic labels based upon religion or superstition and remnants of legal precedent which have not been amended to conform with current theory and research findings impede the normalization and habilitation of the mentally retarded. This chapter examines the history of the methods in which society, the law, and psychology have dealt with mental retardation.

The learned Greeks recognized that mental disabilities, which include both mental illness and mental retardation, were the result of scientifically explainable conditions

rather than evil spirits or demons, but even as recent as the eighteenth century it was thought demons possessed some minds.⁸ Hippocrates, admittedly centuries ahead of his time, sought to classify mental infirmities and to provide clean, comfortable surroundings for persons afflicted with mental disabilities,⁹ thus establishing the protective theory regarding the disabled. However Greek city states dealt very harshly with the mentally retarded sometimes throwing them off mountains and leaving them to die.¹⁰

The first written law dealing with the mentally disabled was included in the Twelve Tables of Rome, 449 B.C., which provided:

If a person is a fool, let his person and his goods be under the protection of his family, or his parental relatives, if he is not under the care of anyone.¹¹

A person was considered mentally disabled when he did not act like other people. The Code of Justinian, 528 A.D. provided that once a guardian was appointed for the mentally disabled person, the person was unable to enter into contracts, marry,

⁸Coleman, J.C., Abnormal Psychology and Modern Life. Glenview, Illinois: Scott, Foresman and Co. (4th Ed.) 1972.

⁹Asch, S.H., Mental Disability in Civil Practice, Rochester, N.Y.: Lawyer's Cooperative Publishing Co., 1973.

¹⁰Gearheart, B.R. & Litton, F.W., The Trainable Retarded. St. Louis: C.V. Mosby Co., 1975.

¹¹Asch, *supra*.

make a will or be guilty of any crime requiring criminal intent.¹² The guardian was in control except when the person was lucid, at which time the person was permitted to control his own affairs. When the period of lucidity passed, the guardian was in control once more. It is not clear how or by whom "lucidity" was defined.

Early Western European cultures also had laws restricting the rights of the mentally disabled. The Visigothic Code of the early Germanic Tribes in 800 A.D. provided:

All persons who from infancy, or indeed from any age whatever, are insane and remain so without intermission, cannot testify, or enter into a contract, and if they should do so, it will have no validity. But such as have lucid intervals, shall not be prohibited from business transactions during those periods.¹⁴

During this historical period many mentally retarded were kept as fools or jesters for entertainment of the elite of Rome and the Germanic Tribes. Some were given special treatment in the belief that they had some connection with God.¹⁵

¹²Id.

¹³Kanner, L., History of the Care and Study of the Mentally Retarded. Springfield, Illinois: Charles C. Thomas, 1964.

¹⁴Asch, supra.

¹⁵Gearheart & Litton, supra.

Thirteenth Century English law contained prohibitions similar to those of the Germanic Tribes and developed two categories of the mentally disabled: 1) lunatic--a person who "hath understanding but...hath lost the use of his person" as a result of a divine visitation and 2) idiot--a person who "hath no understanding from his nativity."¹⁶

In early English common law, upon a petition being filed, a jury could find the person a lunatic or an idiot. In either case, the King was given control over the person and his property. However since "lunatics" had periods of lucidity the King had to account to the "lunatic" for money received from his property during those times when he was lucid. As a result of this difference the jury almost always found the person to be a lunatic so that there was at least a chance that the King's control would not be complete.¹⁷ In England and elsewhere Protestants lead by Luther and Calvin abandoned the earlier theory that the mentally retarded had some connection with God and declared them Godless and possessed by demons.¹⁸

¹⁶ Statute de Praerogative Regis, as quoted in Asch, supra.

¹⁷ Brackel, S.J. & Rock, R.S., The Mentally Disabled and the Law, (Revised ed.). Chicago: University of Chicago Press, 1971.

¹⁸ Gearheart & Litton, supra.

The practice of labeling the mentally disabled was expanded in Seventeenth Century England where the courts established four categories of mentally disabled persons: 1) idiot, or natural fool, 2) a person of good mind who by visitation of God lost it, 3) lunatics who were sometimes lucid and sometimes non compos mentis (totally disabled), and 4) those few like the drunkard who deprived themselves by their own volition.¹⁹

Early English common law required that the mentally disabled could not be guilty of a crime requiring criminal intent because he could not form the necessary criminal intent. In M'Naughten's Case²⁰ Daniel M'Naughten was found not guilty of the murder of Sir Robert Peel's secretary (M'Naughten wished to murder Sir Robert) because he was

laboring under such a defective reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it that he did not know what he was doing was wrong.²¹

When found not guilty by reason of insanity, the mentally disabled often incurred a longer period of confinement and greater stigma than when convicted and incarcerated in jail instead of a mental institution.

¹⁹Beverly's Case, as discussed in Asch, supra.

²⁰10 Clark & Fin. 200, 8 Eng. Rep. 718 (1843).

²¹Id. The current Oregon law on the so-called "insanity defense" is found in ORS 161.295 and is discussed in Chapter III.

In the United States laws in general were originally enacted to deal with property and contracts. Only later were society and then individual rights included. And only very recently have minority rights been included. Laws regarding the disabled were originally to deal with the disabled's property and to protect society by institutionalizing the disabled. In 1667, for example, Massachusetts passed a statute giving town selectmen, similar to our city commissioners, authority to take steps to insure that violently disturbed individuals did not "damnify others".²² In Pennsylvania in 1751 Benjamin Franklin successfully petitioned the Pennsylvania Assembly for the establishment of a hospital which would accept mentally ill patients along with those suffering physical ailments. In Williamsburg, Virginia in 1773 the first hospital solely for the mentally ill was established, and the second one established in Lexington, Kentucky in 1824.²³ In 1788 New York enacted a statute permitting constables to lock up the "furiously mad and dangerous" unless they were in the control of friends or relatives.

²² Asch, *supra*.

²³ *Id.*

[T]here are sometimes persons, who by lunacy, or otherwise are furiously madd [sic] or are so far disordered in their senses that they may be dangerous to be permitted to go abroad.²⁴

In 1848 the first institutions exclusively for the education and care of the mentally retarded were established in Massachusetts.²⁵ Between 1850 and 1860 institutions for the mentally retarded were established in New York, Ohio, Connecticut, and Kentucky.²⁶ In 1890 there were 14 institutions for the mentally retarded in the United States; by 1910 there were 26 and by 1923 the number had increased to 40.²⁷ In the latter nineteenth century the mentally retarded were the "villains of society" and the "mother of crime, pauperism and degeneracy,"²⁸ and as a consequence more and more mentally retarded were removed from society and placed in institutions. Institutional growth paralleled society's fears of the mentally retarded.

²⁴Chapt. 31, New York Laws of 1788.

²⁵Gearheart & Litton, *supra*.

²⁶*Id.*

²⁷Rothman, D., in Kindred, M., Cohen, J., Penrod, D. & Shaffer, T. (eds.) The Mentally Retarded Citizen and the Law. sponsored by the President's Committee on Mental Retardation, New York: The Free Press, 1976.

²⁸Gearheart & Litton, *supra*.

The early twentieth century displaced the nineteenth century emphasis on institutions with an emphasis on special education--first in special schools and then in the public schools. New York, Cleveland, and Providence, Rhode Island were the first to establish special education classes for the mentally retarded within the public schools. The number of mentally retarded in the public schools increased from 8,000 in 1910 to 770,000 in 1975 although only about 50% of the retarded children are now given assistance in special classes.²⁹

The 1950's and 1960's were eras of legislation and national support for the mentally retarded, including legislation enacted to provide for special education for handicapped children.³⁰ Legislation and support were in part the result of efforts by President John F. Kennedy and the National Association for Retarded Citizens. The support for the mentally retarded in the 1950's and 1960's has also been ascribed to 1) thorough disgust with the Nazi practice of extermination of retarded persons, 2) growing interest in

²⁹Id. In 1970 the U.S. Bureau of Education for the Handicapped estimated the number of retarded children as 1,360,737 compared with 707,737 in special education classes. Bureau of Education for the Handicapped, Annual Reports FY 1968 and FY 1969. Washington, D.C., 4. Approximately 25% had no special education. The remainder used a variety of methods. However, the trend is away from special education and toward mainstreaming, discussed in Chapter II.

³⁰Id.

mental retardation by biological and social scientists, 3) renewed interest that little was being done for the handicapped, and 4) a well organized parent movement.³¹

The 1970's thus far have been an era of normalization and litigation. Normalization, a psychological principle discussed in Chapter II, had its beginnings in the Scandinavian countries³² and has been promoted by Wolfensberger in the United States and Canada. The principle directs society to provide services and facilities that permit the individual to function in a manner that is as culturally normal as possible and implies: 1) community level services for the mentally retarded, 2) educational and training programs integrated with "normal" individuals, 3) residential facilities in small units resembling homes, and 4) daily contact with normal adults and the opposite sex, and work alongside the non-retarded.³³

To implement normalization and secure other rights for the mentally retarded, the 1970's have witnessed a proliferation of litigation essentially concerned with the provision

³¹Kott, M.G., The History of Mental Retardation, in Rothstein, J.H. (eds.), Mental Retardation: Readings and Resources. New York: Holt, Rinehart and Winston, Inc., 1971; Sarason, S.B. & Doris, J., Psychological Problems in Mental Deficiency. New York: Harper & Row, 1969.

³²Wolfensberger, W., Normalization: The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation, 1972.

³³Gearheart & Litton, *supra*.

of appropriate education and/or training in the public schools, 2) adequate care, protection from harm, and appropriate training within institutional settings and 3) just and proper compensation for labor.³⁴ The decisions by the courts have held that 1) the mentally retarded and all other handicapped children have a right of free access to public education, 2) institutionalized mentally retarded have a right to receive treatment that will lead to habilitation rather than deterioration, 3) proceedings for commitment or other infringements upon the liberty of the mentally retarded be conducted fairly and if restrictions are imposed they be the least restrictive alternative, and 4) the mentally retarded forced to labor against their will at least be given adequate compensation for all non-therapeutic work.³⁵

LEGAL TERMINOLOGY

Varying terminology from law, medicine, and psychology has clouded communication among professionals--all concerned with mental retardation.

The lawyer came first; it was he, and not the physician who had to manage the consequences of mental disease insofar as they affected the interests of the community. The lawyer was then the first to see to it that the psychotic disturber of the peace be taken

³⁴Id.

³⁵Id.

out of circulation, that the homicidal maniac (or criminal insane) be removed from the community and isolated somewhere, that property mismanaged and abandoned by a person mentally deranged be taken care of in some legitimate way. In other words, all the problems which have preoccupied psychiatry ever since it was born existed to the full extent of their urgency before it was born. Attempts at their practical solutions were made, precedents established, traditions developed, without benefit of any scientific clinical psychopathology; the very possibility of the development of such psychopathology could not be fathomed for many years.³⁶

The law categorizes a person under a specific terminology, and determines his rights accordingly. This practice has been criticized, since much of the terminology is inappropriate or anachronistic, but the categorization process is still utilized in most states.³⁷

The following are some of the terms and definitions used by the courts and definitive case references: 1) dotage--feebleness of the faculties caused by old age;³⁸ 2) feeble mindedness--incomplete development of the mind viewed from a socio-legal standpoint, not necessarily permanent;³⁹

³⁶Zilboorg, Legal Aspects of Psychiatry, in Zilboorg & Hall (eds.) One Hundred Years of American Psychiatry. New York: Harcourt Brace, 1944.

³⁷Kindred, Cohen, Penrod & Shaffer, supra.

³⁸Anderson v. State, 54 Ariz. 387, 96 P.2d 281 (1939).

³⁹Re Masters, 216 Minn. 553, 13 N.W. 2d 487 (1944).

3) idiocy--an absence of all mind or reason from birth;⁴⁰
 4) imbecility--mental weakness which may not amount to incompetency;⁴¹ 5) lunacy--a mind directed by will but misguided by judgment;⁴² 6) monomania--insane on a particular subject, sane on others;⁴³ 7) moral insanity--inability to distinguish from right or wrong;⁴⁴ 8) non compos mentis--total and positive incompetency.⁴⁵

Often different labels are used in different legal contexts. To determine the existence of a mental disability, Oregon, for example, uses: 1) "mental illness" and "mental deficiency" in discussing civil commitment; 2) "competency" in discussing appointment of a conservator or guardian, criminal responsibility and ability to stand trial, ability to enter into contracts, ability to execute a will and ability to obtain a driver's license or testify at a trial; and 3) "mentally handicapped" in discussing education and discrimination in employment and housing.

A difficulty arises from the use of the same label in

⁴⁰Jones v. Commonwealth, 154 Ky. 152, 159 S.W. 568 (1915)

⁴¹Slaughter v. Heath, 127 Ga. 474, 57 S.E. 69 (1911).

⁴²In re Vanauken, 10 N.J. Eq. 186 (1854).

⁴³State v. John, 30 N.C. 330 (1905).

⁴⁴State v. Levelle, 34 S.C. 120, 13 S.E. 319 (1906).

⁴⁵Greenwade v. Greenwade, 43 Md. 313 (1875).

different legal contexts:

The same term may be used in different parts of codes or statutes, even though each of these parts may be designed to accomplish a different result and may be intended to apply to a different class of persons. For example, identical terms are often used to describe persons subject to involuntary hospitalization, and those incapable of caring for themselves. In fact, the law of these areas applies to a different mental condition; hence, it is possible to be "mentally ill" for the purpose of involuntary hospitalization but to have at the same time sufficient capacity to execute a valid will or marry.⁴⁶

In the case of civil commitment the person must be mentally deficient and in need of care, custody or training. "Mentally deficient" is not defined. Based upon the dual requirement of mental deficiency and a need for care, custody and treatment before commitment, it would seem that mental deficiency is viewed by the law as embodying something other than a need for care, custody or training. Statutes relating to the appointment of a guardian or conservator define an "incapacitated person" as one "who is unable, without assistance to properly manage or take care of himself or his personal affairs."⁴⁷ This may offer courts some statutory guidance in determining whether or not a person is mentally deficient, but the decision is ultimately a matter of judicial discretion based upon the testimony of psychologists and psychiatrists who have tested and examined the individual.

⁴⁶Brackel & Rock, supra.

⁴⁷ORS 126.003(4).

PUBLIC AND PRIVATE ORGANIZATIONS

Both public and private organizations have had a tremendous impact upon the research, education, legislation and litigation concerning the mentally retarded. Throughout the years a number of these groups have made significant contributions. The most influential groups are as follows:

1) American Association on Mental Deficiency, founded in 1876 as a largely professional group, has been engaged in research in the prevention of retardation, educational programming, various residential service models and the establishment of standards and procedures for use with the mentally retarded. Their standards include: a) Standards for State Residential Institutions, b) Manual on Terminology and Classification in Mental Retardation, and c) AAMD Adaptive Behavior Scale. It publishes the American Journal of Mental Deficiency and Mental Retardation bi-monthly.

2) National Association for Retarded Citizens, founded in 1950, is highly involved in initiating classes and programs for retarded children and youth and litigation. It is one of the sponsors of the National Center for Law and the Handicapped. NARC has also performed evaluations of certain governmental services dealing with the mentally retarded. It has professional members, but it is primarily a group composed of parents

of the mentally retarded.

3) United Cerebral Palsy Associations, Inc., founded in 1949, is concerned with legislation and education for all handicapped. It has been instrumental in supporting federal legislation in this area and has pursued research on causes of mental retardation, expending approximately one million dollars per year for research.

4) President's Committee on Mental Retardation, founded in 1966, was initially charged to evaluate all federal efforts in the area of mental retardation and devise new ways to combat the problem. In its first year the committee outlined ten top priority areas:

- a) availability of mental retardation services to more of the nation's people;

- b) more effective and extensive manpower recruitment and training programs for work with the mentally retarded;

- c) fuller use of existing resources;

- d) more public-private partnerships in program development, services, and research;

- e) development of a national mental retardation information and resource center;

- f) continuing encouragement of basic research, training in application of research, and rapid translation of research results into service program uses;

- g) immediate, major attention to early identification

and treatment of the mentally retarded;

h) the special needs of the mentally retarded taken into account by social and institutional planning for the coming decades;

i) clarification of the legal status of the mentally retarded individual guaranties of rights; and

j) imaginative ideas and approaches that will make new advances possible by everyone interested in helping the mentally retarded and combating retardation.⁴⁸

The President's Committee has sponsored publication of articles and books explaining the importance of deinstitutionalization and normalization, e.g. The Mentally Retarded Citizen and the Law and Changing Patterns in Residential Services for the Mentally Retarded. It has had considerable impact on the federal legislation dealing with habilitation also.

PSYCHOLOGICAL TERMINOLOGY

Despite the efforts of the above groups, the law has yet to rid itself of many archaic and invalid legal definitions for mental retardation. While there is in psychology no single universally accepted definition of mental retardation, there is general agreement that diagnosis of mental

⁴⁸Gearheart & Litton, supra.

retardation should be based upon at least three criteria:

1) measured intelligence, 2) adaptive behavior level and 3) medical classification based on physical infirmities and disabilities.⁴⁹ The definition developed by the American Association on Mental Deficiency is widely accepted:

mental retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.⁵⁰

Intellectual functioning is measured by an individual standardized test of intelligence and performance, and adaptive behavior by how well the person meets the standards of his age and cultural group.⁵¹ The ranges of retardation based on these two standards have been labeled for

⁴⁹Roos, P., Basic Facts About Mental Retardation, in Ennis, B. & Freidman (eds.) 1 Legal Rights of the Mentally Handicapped, New York: Practicing Law Institute, 17, 1973.

⁵⁰Manual on Terminology and Classification in Mental Retardation, 5 American Association on Mental Deficiency, Special Publication Service No. 2, Grossman, H. (ed.), 1973. The Diagnostic and Statistical Manual for Mental Disorders, (2nd ed.) Washington, D.C.: American Psychiatric Association, 1968, defines mental retardation as "subnormal general intellectual functioning which originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation or both." p. 14.

⁵¹Gearheart & Litton, supra. Available scales include: AAMD Adaptive Behavior Scales, Alpern-Boll Developmental Profile, Blathazar Scales of Adaptive Behavior, Bristol Social Adjustment Guides, Cain-Levine Social Competency Scale, Fairview Behavior Evaluation Battery, Gardner Behavior Chart, Hospital Adjustment Scale, Newman-Doby Measure of Social Competence, Preschool Educational Attainment Record, Progress Assessment Chart of Social Development, Social Competence Rating, and Vineland Social Maturity Scale, Robinson & Robinson, supra, 359.

descriptive convenience as; 1) mildly retarded, 2) moderately retarded, 3) severely retarded, and 4) profoundly retarded.⁵²

Retardation is partially a social classification, non-existent in a vacuum. It is a product of interaction between individual capabilities and social demands, resulting in what is termed "deficits in adaptive behavior". One mentally retarded person could be reclassified if either his functioning improved or the social demands made upon him changed. Like mental illness, retardation is a label applied to a very diverse population. At least 250 causes of mental retardation have been identified, resulting in individuals with widely varying degrees of intellectual and adaptive functioning.

⁵² National Association for Retarded Children, Facts on Mental Retardation 5 (1971). In order to place the categories in perspective the word descriptions and corresponding I.Q. ranges are as follows:

	Stanford-Binet SD-16	Wechsler SD-15
mild	52-67	55-69
moderate	36-51	40-54
severe	20-35	25-39
profound	below 20	below 25

I.Q. should not be the only diagnostic criterion. The person's developmental history, academic and vocational achievement, motor skill, and emotional and social maturity should also be considered in making evaluations of retardation.

In 1970 approximately 3% of the general United State's population was mentally retarded. Of this mentally retarded population 89% were classified as mildly retarded, 6% moderate, 3 1/2% severe, and 1 1/2% as profound. National Association for Retarded Children, supra, p.15, n.1.

Mental retardation specialists have been called upon to testify in court on the definition of mental retardation. An example of such a case is New York State Association for Retarded Children and Parisi v. Carey.⁵³ Parisi was a class action brought by residents of the Willowbrook Development Center on Stanten Island, New York against state administrators controlling the facility and the Governor of New York. The court found that the residents had a right to treatment and after further testimony, the parties agreed to certain minimal habilitation standards. Dr. James D. Clements, a member of the President's Committee on Mental Retardation and past president of the American Association on Mental Deficiency, observed that mental retardation is not a single behavior:

Individuals with the same medical diagnosis and same level of measured adaptive behavior may still differ widely as to the pattern of their ability, the signs and symptoms that they exhibit and the variety of other characteristics they demonstrate.⁵⁴

⁵³No. 72-C-3567351 (E.D. N.Y., April 30, 1975) as reported in The Mental Disability Law Reporter, 1977, I(4) 229.

⁵⁴Id.

More than 275,000 people are institutionalized in the nation's public and private residential facilities for the mentally retarded, according to the President's Committee on Mental Retardation. This number represents less than 4% of all mentally retarded persons; the remaining 96% reside in the community.⁵⁵ As a result of efforts by many groups, such as the National Association for Retarded Citizens and the President's Committee on Mental Retardation, it is increasingly accepted that very few of those classified as mentally retarded are severely retarded, the majority being mildly or moderately retarded.⁵⁶ The concept of custodial care, based on the presumption that mental retardation is an irrevocable status (often a self-fulfilling prophecy), has changed to a developmental model: the mentally retarded are capable of growth and learning regardless of their level of retardation

⁵⁵ Fact Sheet on Mental Retardation, Multnomah Association for Retarded Citizens, October, 1974.

⁵⁶ See note 52.

or age.⁵⁷

Generally the causes of mental retardation fall within nine categories following or associated with: 1) infection such as rubella during the first trimester of pregnancy, intoxication, carbon monoxide or lead poisoning, 2) trauma, 3) metabolism disorder or poor nutrition, 4) a growth such as a cyst or tumor or gross postnatal brain disease, 5) diseases and conditions due to unknown prenatal influence, 6) prematurity, 7) genetic abnormality, 8) major psychiatric disorder, 9) psycho-social deprivation and 10) unknown or uncertain causes.⁵⁸

The autistic child is sometimes included in the broad category of mentally retarded. Autism begins in infancy and is characterized by an inability to relate to others, specific

⁵⁷Roos, P., McCann, B. & Patterson, E.G., A Developmental Model of Mental Retardation, paper presented at 1970 Annual Convention of National Association for Retarded Children. "Children who are classified as mentally retarded, although limited in their potential for advanced academic achievement can usually be brought by special education to a state of self-sufficiency as adults. Moderately retarded...can learn to take care of their personal needs and perform many useful tasks in the home or in a sheltered working situation. The severely retarded...can learn self-care, and...in such areas as behavior control, self-protection, language development and physical mobility." National Association for Retarded Children, Facts on Mental Retardation, p.4, n.1, 1975.

⁵⁸Baumeister, A.A., Mental Retardation. Chicago: Aldine Publishing Co., 1967. The listing is based upon etiology classifications derived by the American Association of Mentally Disabled and The Diagnostic and Statistical Manual of Mental Disorders (2nd ed.), supra.

language problems, and a concern for maintaining sameness.⁵⁹ In contrast to the often warm and affectionate retarded child, the autistic child displays aloofness and appears cold and detached. Behavior therapy has been used effectively with the autistic--the most widely known the project based at UCLA.⁶⁰ Although many of the same procedures are used with the autistic as with the mentally retarded, autism refers to a fairly rare syndrome, not included in this paper.

Research is continuing to assist in determining the causes of mental retardation. While prenatal care, genetic counseling, nutrition, and control of toxins such as lead offer hope for curtailing its pervasiveness, mental retardation will continue to exist. This paper will not review the literature on the etiology of retardation,⁶¹ but rather is concerned with the habilitation or normalization of the mentally retarded and the legal provisions for treatment.

⁵⁹Coleman, supra.

⁶⁰Lovaas, O.I. & Koegel, A.L., Behavior Therapy With Autistic Children, in Yearbook of the National Society for the Study of Education. Chicago: University of Chicago Press, 1973.

⁶¹The interested reader should see Robinson, N.M. & Robinson, H.B., The Mentally Retarded Child: A Psychological Approach. New York: McGraw-Hill Book Co., 1976; Baumeister, supra; and Gearheart & Litton, supra for more discussion.

SUMMARY

Mental retardation has been recognized for centuries. Society's attitudes have shifted from ostracism and death to habilitation and training, seldom seeking association with the mentally retarded except for purposes of ridicule and entertainment. At various times in history, an obligation to the mentally retarded person has been recognized, but perhaps more strongly to the mentally retarded's family and friends. In any event, for at least 2500 years laws have been enacted affecting the rights of the mentally retarded.

Especially in England and the United States, law is based on precedent. A statute or judicial ruling once established is difficult to overcome and change.⁶² Since laws dealing with the mentally retarded have been in existence for approximately 2400 years before formal psychology began, many of the restrictions imposed upon the mentally retarded are anachronistic, failing to take into consideration the potential of the mentally retarded for development and training. While the law has been aware of diversity of persons within the classifications of mental retardation by creating labels for groups perceived as having certain characteristics, its labels are often antiquated and are not based on any

⁶²Stare decisis is the Latin term used by courts to indicate established judicial precedent. In the case of judicial opinions unless some good cause is shown, a prior decision may be refined but it will be overruled.

recognized tests nor identifiable behavior.

Psychologists are tending toward more narrow definitions and specific classifications due to the heterogeneity of those termed mentally retarded, and have devised tests for identifying and classifying persons within the group. Much has been discovered about the kinds of activities mentally retarded people can learn and methods for teaching them. Mental retardation specialists generally agree on promotion of the least restrictive setting and as normal a life as possible for the retarded.

Increasingly the legal and psychology professions are interacting in courtrooms, legislative and administrative hearings and in professional publications on the question of mental retardation and in particular the right of the mentally retarded person to "treatment" or "habilitation" as used by attorneys and judges and "normalization" as used by psychologists.

Litigation in the 1960's and 1970's has given rise to the right to treatment discussed in Chapter IV. Habilitation is the current legal standard in both judicial opinions and legislation and normalization the principle most used by psychologists. In the following chapter the normalization principle and other psychological concepts are examined. Chapter III then overviews present laws as they affect the daily rights of the mentally retarded since many present laws seriously constrain efforts of habilitation.

CHAPTER II

CURRENT CONCEPTS IN MENTAL RETARDATION

Treatment of mental retardation is affected by attitudes of society, the law, and medical and psychological understanding, theory and research. As outlined in Chapter I, concepts of mental retardation and the ensuing treatment of the retarded by society, by the health professions, and under the law, have undergone dramatic changes. The fact that the group labeled retarded is not homogeneous adds to the confusion; definitions are complex.⁶³ Important issues before the law (definition and classification, right to education, right to treatment, right to monetary reward for services) are being considered, but it is a new and unsettled area of law. As will be discussed in Chapter IV, there are no significant court decisions

⁶³The specific populations referred to in this paper, those involved in research summarized in this chapter, those referred to when discussing theories of normalization and a developmental model, and those considered in legal cases and legislation, include all those in the DSM II Classification of mental retardation.

on several important issues and conflicting decisions on others. The predominant concept of the mentally retarded under the law is as a child--to be protected and cared for, and secondarily to promote his individual growth and rights, as will be discussed in Chapter III. Courts and legislatures increasingly seek answers to questions regarding treatment as well as definition and classification.

In psychological literature there has been a reaction to the earlier enlargement of the definition of mental retardation.⁶⁴ The trend is to narrow the definition and to deal with the retarded as individuals with many different skills, abilities and needs for treatment. It is important to restrict generalizations from court cases as well as from studies to specific groups because the retarded are such a heterogeneous group. Laws broadly stated may be as harmful as studies too broadly generalized.

This chapter examines the archaic models of mental retardation, some present conditions in treatment facilities, emerging ideologies, some specific treatment facilities or applications reflecting the current theories, recent research dealing with treatment, and methods of evaluating treatment.

⁶⁴Robinson & Robinson, *supra*.

ARCHAIC MODELS

As seen in Chapter I, the law has generally espoused a protective attitude for the mentally retarded. In practice society has generally ostracized the mentally retarded except for amusement purposes. Treatment which has been provided has been based on the assumption that the mentally retarded are less than human. The mentally retarded have been placed in five destructive , archaic models which have justified rejection and exclusion from the mainstream of society.⁶⁵ These archaic models assure that the mentally retarded will be isolated from community life and denied access to services essential for functioning as a human being.⁶⁶

These five destructive archaic models are: 1) the mentally retarded are subhuman organisms lacking the needs, aspirations and sensitivities of other human beings, and are therefore to be allowed minimal freedom with little or no regard for their human rights, 2) the mentally retarded are a menace to society because of their criminal tendencies and their propensity to procreate mentally retarded offspring with

⁶⁵Wolfensberger, W., Normalization, supra.

⁶⁶Roos, P., Basic Facts About Mental Retardation in Ennis & Friedman (eds.), supra.

similar tendencies thereby justifying their control in prison-like institutions, 3) the mentally retarded are "suffering" and are therefore objects of pity to be kept contented and be protected from themselves and others, 4) the mentally retarded, with I.Q.'s and intellectual abilities comparable to children, are to be protected and kept "happy" as some would treat the eternal child, 5) the mentally retarded are sick and therefore in need of hospitalization in clean, well organized institutions with adequate medical services. Since there is no known technique for regenerating brain tissue, their condition is hopeless and "custodial" care in hospital-like settings is the best that can be done.⁶⁷

None of these five models recognize that the mentally retarded are not sub-human but are fully participating members of the human race⁶⁸ and are capable of learning and growth. The mentally retarded are not a criminal menace,⁶⁹

⁶⁷Id.

⁶⁸United Nations General Assembly, Declaration on the Rights of Mentally Retarded Persons, Twenty-sixth session, A/RES/2856 (XXVI) 1972.

⁶⁹Conley, R., The Economics of Mental Retardation. Baltimore: John Hopkins University Press, 1973; Levy, S., The Role of Mental Deficiency in the Causation of Human Behavior, American Journal of Mental Deficiency, 1954, 58, 455.

and they are only slightly more likely than the non-retarded to have retarded children.⁷⁰ Overprotection and dehumanization by treating the mentally retarded as objects of pity, eternal children or hopelessly sick prevents their training and development.⁷¹

These archaic models are destructive and may keep the mentally retarded in large institutions where they receive only custodial care or even if living in private institutions, or with family or friends their potential may not be realized.

PRESENT CONDITIONS

Present conditions in the institutions for the mentally retarded may be improving, but only slightly. Not only is the developmental model either not recognized or not implemented, conditions are often deplorable. In 1948 the conditions at the Philadelphia State Hospital for Mental Diseases were described:

I entered buildings swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own. I saw hundreds of patients lying under leaking roofs, surrounded by moldy, decaying walls, and sprawling on rotting floors for want of seats or benches.

⁷⁰Kaplan, A.R., Genetics, in Wortis, J. (ed.) Mental Retardation: An Annual Review, 57-62. New York: Grune & Stratton, 1972.

⁷¹Roos, supra.

...Many of the attendants, I was told, were vagrants recruited directly from courts and police stations where they were reportedly given the choice of a jail sentence or going on the Byberry [the hospital] payroll.⁷²

In 1968 a study of several institutions revealed the following conditions:

In each of the dormitories for the severely retarded residents there there is what is euphemistically called a day room or recreational room. The odor in each of these rooms is over-powering. After a visit to a day room we had to send our clothes to the dry cleaners to have the stench removed. The facilities often contribute to the horror. Floors are sometimes wooden and excretions are rubbed into the cracks, leaving permanent stench.

...The question one might ask is, Is it possible to prevent these conditions? Although we are convinced that to teach severely retarded to wear clothes one must invest time and patience, we believe it possible to do so--given adequate staff. There is one more requirement. The staff has to be convinced that residents can be taught to wear clothes, that they can be engaged in purposeful activities, that they can learn to control their bladders. The staff has to believe their "boys" and "girls" are human beings who can learn. Obviously, the money and the additional staff are vitally important. However, even more important, is the fundamental belief that each of these residents is a human being.⁷³

The report of the Joint Special Commission on Belchertown State School and Monson State Hospital in Massachusetts in March, 1971 found old, crowded, sparsely furnished buildings with inoperative fire alarm systems and doors. There were

⁷²Deutsch, A., The Shame of the States. New Jersey: Prentice-Hall, 1948, 26.

⁷³Blatt, B. & Kaplan, F., Christmas in Purgatory--A Photographic Essay on Mental Retardation. Boston: Allyn & Bacon, 22, 1966.

shortages of sanitation supplies and cockroach infestation. The residents had no privacy, received abusive punishment and unnecessary and incorrect medication.⁷⁴ It has been stated by those observing many institutions that one is entering the "land of the living dead" or "stumbling into a dung hill, regardless of how it is camouflaged."⁷⁵

EMERGING PRINCIPLES

Inappropriate myths are being replaced by new concepts or principles which, if implemented by law, hold promise of releasing institutionalized mentally retarded not only from squalid conditions in some institutions, but out of the institutions and of providing appropriate training and education for the non-institutionalized.⁷⁶ One such principle is the developmental model which essentially provides that mentally retarded people be viewed developmentally as persons capable of growth and learning. Programs for retarded based on

⁷⁴Rice v. Greenblatt, No. 72-469F (M.D. Mass., filed Feb. 7, 1972, complaint for plaintiff.) See also Offer, C.W., Field Report, Psychology Today, 1974, 61 for a general discussion of some current conditions.

⁷⁵Blatt & Kaplan, *supra*.

⁷⁶Roos, *supra*.

a developmental model have as their goals: 1) increasing the complexity of the individual's control; 2) increasing the individual's control over his total environment; and 3) optimizing each person's human qualities.⁷⁷ The developmental model rejects custodial care and cautions against the use of labels.⁷⁸

A second concept is normalization. Wolfensberger, the ideology's chief spokesperson, has defined "normalization" as

utilization of means, which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible.⁷⁹

Under the normalization model deviation from the normative must be justified by demonstrating that the deviation is more successful than normalization for a particular individual.⁸⁰ An important element of the model is that each person live in the least restrictive setting and that the least drastic alternative among equally effective potential programs or treatment options be utilized.

⁷⁷ Roos, P., McCann, B. & Patterson, E.G., A Developmental Model of Mental Retardation, paper presented at the 1970 Annual Convention of NARC.

⁷⁸ Roos, supra

⁷⁹ Wolfensberger, Normalization, supra, 28.

⁸⁰ Roos, P., Parent Organizations, in Wortis, J. (ed.) Mental Retardation, supra.

[T]he normalization principle means making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society.

This principle should be applied to all the retarded, regardless whether mildly or profoundly retarded, or whether living in the homes of their parents or in group homes with other retarded. The principle is useful in every society, with all age groups, and adaptable to social changes and individual developments. Consequently, it should serve as a guide for medical, educational, psychological, social, and political work in this field and decisions and actions made according to the principle should turn out more often right than wrong.⁸¹

A third concept, deinstitutionalization, is closely aligned with the element of least restrictive treatment and is similar to normalization albeit more limited in scope.⁸² The deinstitutionalization model views institutions as the most restrictive and least likely to yield desired results of all practiced treatment forms. Residential care and small group homes in the community are seen as desirable substitutes to the custodial care provided in institutions. Outside the institution there are also opportunities for social learning and behavioral techniques which have been successful in the

⁸¹Kugel, B. & Wolfensberger, W. (eds.) Changing Patterns in Residential Services for the Mentally Retarded. Washington, D.C.: President's Committee on Mental Retardation, 1969, 181.

⁸²Wyatt v. Stickney, supra, 391, n.7. Testimony of Dr. Phillip Roos, Executive Director for National Association for Retarded Children.

growth and learning of the mentally retarded.⁸³

A fourth concept is mainstreaming which has as its goal implementation of normalization in education by allowing retarded children to attend classes along with nonretarded children for all or most of the school day.⁸⁴ There are various plans but all involve specialized help to both pupils and teachers. The assumptions underlying the use of mainstreaming include 1) the special classroom is an isolating experience for retarded children, 2) retarded children are better able to achieve, both academically and socially when exposed to models whose achievement in both areas is more expert than their own; 3) the regular classroom bears a greater resemblance to the real world, and 4) exposure to handicapped children helps other children understand and accept them.⁸⁵

It has been suggested that in order for mainstreaming to work most effectively labeling must be avoided.⁸⁶ In addition care must be taken to assure that the retarded

⁸³Watson, L.S., Jr., Behavior Modification of Residents and Personnel in Institutions for the Mentally Retarded in Baumeister, A.A. & Butterfield, E. (eds.) Residential Facilities for the Mentally Retarded. Chicago: Aldine, 1970.

⁸⁴Robinson & Robinson, *supra*.

⁸⁵*Id.*

⁸⁶*Id.*

child be given equal educational opportunity.⁸⁷ Educational administrators may be reluctant to expend additional funds to provide proper opportunity for the retarded student when he is in a classroom with nonretarded children. It is in the state's interest financially, however, to furnish an appropriate education for the handicapped child. It is also its moral obligation to maximize each individual's potential for happiness and human dignity. This latter approach focuses on the true meaning of education: helping the child adjust to his environment as well as he can.⁸⁸

⁸⁷ "[Many judicial decisions...still define equality on a 'sameness' doctrine, equal resources to 'children whose needs are unequal.' Such a philosophy may have been appropriate for a society that was based on family economic production that could absorb those who could not compete equally in the nation's economic system. Today, however, the education of a child is a community concern, for if he is not given skills sufficient for economic participation, then he will become dependent upon the community." Weibtraub & Abeson, *Appropriate Education for all Handicapped Children: A Growing Issue*, Syracuse Law Review, 1972, 23, 1037, 1055.

⁸⁸ Comment: *The Handicapped Child Has a Right to an Appropriate Education*, Nebraska Law Review, 1976, 55, 637.

APPLICATIONS

There is general agreement among psychologists that the principle of normalization, which in essence embodies most aspects of the models delineated above, offers the greatest opportunity for the mentally retarded person to achieve his or her optimum development. It is therefore helpful to examine how this principle has been implemented in the actual care of the mentally retarded. An examination of the care and treatment of the mentally retarded in Sweden, Nebraska and Oregon are illustrative of the principle in actual practice.

Sweden has generally adopted the principle of normalization for its delivery of services for the mentally retarded,⁸⁹ and uses mainstreaming and deinstitutionalization to achieve normalization. Under its system retarded children are integrated into nonretarded classrooms, the overall class size is reduced, and a teacher's aid is added to permit individual instruction while placing the retarded child in a more normal setting than he would experience in a special class. A few students live in boarding school with parents receiving instruction in how to care for the mentally retarded child at home and governmental allowances for expenses incurred.

⁸⁹ Grunwald, K., Sweden, in Kugel & Shearer, supra.

Moderately and mildly retarded adults generally live in group homes with approximately six to eight other mentally retarded adults. The homes are in a community setting with the staff, which is available for continuous advice on leisure activities and inter-personal relationships, living elsewhere.

Severely retarded children and those who cannot live with their own families live in residential homes with a family. Parents maintain frequent contacts with their children and may take the children home for weekends or holidays. Residential homes, averaging approximately seven mentally retarded per home are located in the communities. While residential homes are more structured than group homes, residents there generally have their own rooms and take part in daytime activities of an industrial or occupational-therapeutic nature in the community.

For severely retarded adults with antisocial behaviors there are special hospitals with an average of 240 beds. Only a small percentage of the mentally retarded reside in the hospital and usually for only short term care. The numbers of mentally retarded in these hospital facilities are being reduced annually. The mentally retarded who begin in these institutions are progressively moved to residential homes and then to group homes as they are able to do so.

The plan in Sweden is for integration of the mentally

retarded into the community and development of his or her independence. It is organized on the principle of the small group being the most effective way for the mentally retarded to achieve normalization. Those placed in larger institutions are placed there for a short term with the goal of reducing restrictions as progress is made. Progress is followed by governmental ministries, unassociated with any institutions, through filed records and reports and visits with the mentally retarded themselves to insure conformity with the general principle of normalization.⁹⁰

In Nebraska a system has been developed to supplement the existing state programs with deinstitutionalization as its goal.⁹¹ The system's primary purpose is to provide a continuum of services to meet the needs of all retarded citizens in Nebraska. The services include:

1) Developmental and educational services. Mentally retarded who because of age or severity of mental retardation are unable to participate in mainstream public educational programs may be enrolled in developmental center programs to

⁹⁰Id.

⁹¹Lensink, B., Encor, Nebraska, in Kugel & Shearer, *supra*.

obtain training in daily living, language, and group interaction according to individual needs. Included in these services are the developmental maximization unit, designed to provide care for the more severely retarded's medical needs and to provide certain basic skills in intensive training sessions, and the behavior shaping unit, which seeks to provide intensive developmental services based upon the principles of applied behavior analysis.

2) Vocational Service Centers. These centers are designed to provide a wide range of evaluation and training services in the community. The mentally retarded are given an evaluation of their employment capability and training to foster maximum development and growth. Groups of mentally retarded persons who have been evaluated may be employed in community business and industry under a subcontract with the business or industry. The retarded worker is thus able to work under the supervision of a mental health professional and to work with and model after non-retarded workers in a normal work setting. The goal of the program, independent community employment, is completed by job development and assistance in obtaining employment.

3) Residential Services. Families are encouraged to have their mentally retarded child remain at home. When this is not possible a child may be placed in a long term setting with a family. Some children between the ages of three and 15 may live with up to five other retarded children in a duplex or apartment in an established neighborhood with surrogate parents. The children assist in performing routine household tasks similar to actual family settings, such as house cleaning and laundry. Some children who are more severely retarded and thus unable to function in a family-type setting may be placed in a developmental maximization or behavior shaping unit described in (1) above. The most structured residence for children has special programs available. Placement of these children may have been initiated by the courts, but the long term placement goal is in less restrictive and more normalized settings as soon as possible.

Adults may live in an adult training residence where they may develop close relationships with a small group of friends or in an adult family living home in which the mentally retarded lives with up to two other mentally retarded adults and a non-retarded family. In both of these the adult is integrated into the community as normally as possible

Oregon offers a variety of services to the mentally retarded although the emphasis is on education. The normalization principle is espoused, but more work is required to achieve this goal.⁹³ A brief review of the types of services provided include:

1) Preschool programs. These are individual programs focusing on physical, intellectual, emotional, and social development at an early age. Many programs include parent training, infant stimulation in the home and preparation for transition into public school.⁹⁴

2) Trainable mentally retarded classrooms. For children who are too retarded to be classified as educable mentally retarded, programs are provided which emphasize development in communication, social, motor-physical, quantitative, practical, and community living skills. Parents are trained to teach certain skills to their children in the home so that the education process is not limited to the school setting.

3) Student progress records. These standardized tests are given to mentally retarded in educational programs twice

⁹³Gearheart & Litton, *supra*, 219.

⁹⁴Directory of Programs and Services: Developmental Disabilities. Portland, Oregon: United Cerebral Palsy, Inc., 1977.

a year to provide a standardized means for collecting student performance data and to provide a tool for evaluating the programs offered. Nineteen skill areas are tested.

4) Work activity centers. These nonresidential centers are available for the mentally retarded who are unable to participate in a sheltered workshop. Productivity is of less importance than the therapeutic aspects of the work.⁹⁵

5) Sheltered workshop programs. These generally private programs provide the mentally retarded and other disabled persons with opportunities for improving job performance and increasing work productivity while manufacturing and marketing a product for consumer use.⁹⁶

6) Group homes. These facilities are located in the community and vary in size. They offer a variety of programs including education, crafts, recreation, occupational training, speech therapy and activity centers.⁹⁷

95

Gearheart & Litton, supra. Portland Habilitation Center, in addition to specific job training in food handling, custodial, and warehousing also provides work adjustment training, personal adjustment and an activity center. Directory of Programs, supra.

96

Goodwill Industries is an example of such a sheltered workshop program in which the mentally and physically disabled repair donated household items for resale at its own outlets.

97

On June 22, 1977, the application of St. Vincent de Paul Rehabilitation Service of Oregon, Inc., was granted an application to construct the B.P. John Development Center for the mentally retarded. The 19 bed facility is to provide diagnostic, psychological, psychiatric, therapeutic, vocational and avocational services for the mentally retarded.

8) Institutions. Oregon has two large residential institutions for the mentally retarded--The Eastern Oregon Hospital and Training Center in Pendelton and the Fairview Training Center in Salem.⁹⁸ The two state operated institutions house mentally retarded who were either involuntarily committed or voluntary admitted to a state mental health facility.⁹⁹ The institutions are generally restricted in the habilitation services provided.¹⁰⁰

98

The actual physical facilities of the Fairview Training Center, formerly the Fairview Hospital and Training Center, have been viewed by millions of Americans, since many of the scenes for the film, One Flew Over the Cuckoo's Nest were shot on location there.

99

Voluntary admission and involuntary commitment are discussed in Chapter III.

100

Tupper v. Fairview Hospital and Training Center, 276 Or. 657, ___ P.2d ___ (1976) gives some indication that many of the restrictions are being reduced and there is at least some effort in providing treatment. (Tupper who was employed at the institution as a psychiatric aide had as one of his duties the supervision and training of "residents" living in one of several small, dormitory-like "cottages." His responsibilities included maintaining a "program book" in which the progress made by his residents in various training programs was recorded. When he either lost or failed to keep the book, he was discharged. Tupper appealed his discharge, which was affirmed by the courts.)

RESEARCH

Research purposes, procedures, and design on mental retardation have been as varied as the large, heterogeneous population itself. The rather recent, but rapidly increasing research has been basic and applied, with conclusions drawn from studies with the mentally retarded population and from generalized learning principles from studies with normal populations. Studies have been done with mildly retarded "slow" learners to the profoundly retarded and in classrooms, wards, group homes and work settings. There are at least three broad areas of research involved with retardation: 1) etiology, diagnosis and classification, and prevention; 2) basic laboratory research on learning and memory processes; and 3) learning and other principles applied in vocational, educational, and treatment facility settings. It is the research concerned with treatment facilities and plans in the third area that is of primary interest when considering the right to treatment, but conclusions from the other areas and their implications for treatment/habilitation plans are mentioned first.

Etiology

The first area is a medical approach, dealing with etiology, diagnosis and classification, and prevention.

A majority of federal funding for research in mental retardation and a primary thrust of the President's Committee on Mental Retardation is on discovering etiology and methods of prevention. Factors involved in etiology include brain damage, genetics, physical environment, psychological, and psychosocial disadvantage. The genetic versus environmentalist debate is partially responsible for the thrust of research and interest in etiology. The 1959 AAMD Diagnostic Manual attached importance to the role of genetic factors while the 1973 version reflects a very environmentalistic position. The fact remains that in most cases a cause is unidentified. Treatment or habilitation plans might be better made when causes are known but such plans cannot await a full understanding of etiology, nor do they need to in order to be effective.

Lab Research

The second area of research deals with learning and memory. As basic lab research, this is one of the most active areas in psychology in general and in the field of mental retardation in particular since, by definition, a fundamental difference in the retarded is a slower, more inefficient way of acquiring knowledge and skills. Between

1954 and 1974 over 1500 studies of learning processes were conducted with retarded individuals.¹⁰¹ Vocational training, academic education, and learning self help and basic living skills are essential in any habilitation program. Robinson and Robinson conclude from a review of research on learning and memory processes in the retarded that a major problem for the retarded is the inability to employ strategies. They also conclude that training in most aspects of learning is effective, but generalization of effects is very limited.¹⁰² Weisberg¹⁰³ reviewed operant procedures in lab research with the retarded and, while suggesting that generalizations to nonlaboratory settings are especially difficult with retarded, concludes that all retarded seem capable of some degree of learning.

Berkson and Landesman-Dwyer,¹⁰⁴ in a review of behavioral research on severe and profound mental retardation, (1955-74) document a large scientific literature on the

¹⁰¹ Robinson & Robinson, *supra*,

¹⁰² *Id.*

¹⁰³ Weisberg, P., Operant Procedures With the Retardate: An Overview of Laboratory Research, in Ellis, N.R. (ed.) International Review of Research in Mental Retardation, Vol. 5. New York: Academic Press, 1971, 113-145.

¹⁰⁴ Berkson, G. & Landesman-Dwyer, S., Behavior Research on Severe and Profound Mental Retardation (1955-1974), American Journal of Mental Retardation Deficiency, 1977, 81, 428.

behavioral potential of severely and profoundly retarded persons. As a result of the trend toward emphasis on an experimental orientation from the previous emphasis on diagnosis and classification, it has been repeatedly shown that the severely-profoundly retarded no longer should be considered hopeless and untrainable.¹⁰⁵ This body of research validates the right to treatment movement in that it suggests that all retarded can benefit from treatment and therefore are entitled to treatment/habilitation and not to be placed on back wards in a custodial manner.

Vocational and Educational Settings

The third area deals with research in vocational, educational and treatment facility settings. Gold has reviewed research on vocational habilitation prior to 1973.¹⁰⁶ He states that vocational training of the mentally retarded, which presently utilizes resources of the three primary disciplines--rehabilitation, psychology and education, should also use industrial management and industrial engineering as sources for training the mentally retarded. Schools and

¹⁰⁵Id.

¹⁰⁶Gold, M.W., Research on the Vocational Habilitation of the Retarded; The Present, The Future, in Ellis, N.R. (ed.) International Review of Research in Mental Retardation. Vol. 6. New York: Academic Press, 1973, 97.

workshops are the major sources for training the retarded.

The sheltered workshop movement has resulted in the establishment of three main types of workshops for the retarded: the transitional shop, where clients coming from school programs, homes, or institutions prepare for placement into competitive employment; the extended care or terminal shop, where clients believed to be incapable of achieving competitive employment work for indefinite periods; and the comprehensive shop which attempts to service both types of clients.¹⁰⁷

The current trend is toward a program of habilitation combining academic instruction, vocational classes, and on-the-job training. Programs individually designed, as called for in the Wyatt decision, are most successful. The programs state that on-the-job expectations and amounts of responsibility and freedom are gradually increased; however, Gold notes two discrepancies between plan and implementation. First, although opportunities exist, "training... almost without exception refers to exposure rather than treatment, or it refers to placing clients on a job station where it is hoped training occurs."¹⁰⁸ Crossman¹⁰⁹ in an article

¹⁰⁷

Id.

¹⁰⁸

Gold, [^]Supra, 100.

¹⁰⁹

Crossman, J.E., A Technique for Programming Sheltered Workshop Environments for Training Severely Retarded Workers. American Journal of Mental Deficiency, 1969, 73, 814-818.

on severely retarded workers, noted that the usual pattern is to find work that retardates can do instead of training.

Gold's review, primarily descriptions of facilities and programs, notes poor incentives for the mentally retarded as a further discrepancy between plan and implementation. In most facilities the most obvious incentive, money, was usually given noncontingently in very small amounts. There was little opportunity for the acquisition of skills in money management since everything was free. The pay scale for workers in institutions and sheltered workshops has recently undergone a tremendous change.¹¹⁰ The situation would be excellent for testing the effects of token and monetary rewards for work, except for at least two disadvantages for research--limited staff and dependence of workshops on contracts. But Gold reports that monetary and token

110

Weidenfeller v. Kidulis, supra. (Institutions residents who were not paid for work they were required to perform could obtain any withheld pay and other related damages in the courts if they could also show the work was nontherapeutic.)

systems¹¹¹ and goal setting by the workers and the presence of a model worker¹¹² and video-taped playback of on-the-job performance¹¹³ did increase productivity.

Birnbrauer in a more recent review also acknowledges problems in research but has seven general conclusions regarding research on vocational habilitation and the retarded:¹¹⁴

1) Combined use of modeling and reinforcement principles has been shown to be more effective than less systematic approaches in increasing skills. The results were most impressive when the behavior measured was attention to work.

¹¹¹Huddle, D.D., Work Performance of Trainable Adults as Influenced by Competition, Cooperation, and Monetary Reward. American Journal of Mental Deficiency, 1967, 72, 198; Hunt, J.G. & Zimmerman, J., Stimulating Productivity in a Stimulated Sheltered Workshop Setting. American Journal of Mental Deficiency, 1969, 74, 43; Logan, D.L., Kinsinger, J., Shelton, G. & Brown, J.M., The Use of Multiple Reinforcers in a Rehabilitation Setting. Mental Retardation, June, 1971, 9, 3.

¹¹²Kliebhan, J., Effects of Goal-setting and Modeling on Job Performance of Mentally Retarded Adolescent. American Journal of Mental Deficiency, 1967, 73, 220.

¹¹³De Roo, W.M. & Haralson, H.L., Increasing Workshop Production Through Self-Visualization on Videotape. Mental Retardation, August 1971, 9, 22.

¹¹⁴Birnbrauer, J.S., Mental Retardation, in Leitenberg, H. (ed.) Handbook of Behavior Modification and Behavior Therapy, New Jersey: Prentice-Hall, 1976, 361-404.

He recommends analyzing the components of strategies, hypothesis testing, problem solving, and abstracting relevant information and developing programs to teach these problem-solving skills as well as specific tasks.

2) Combinations of instructions, demonstrations, physical guidance, and reinforcement have effected changes in a variety of responses with many retardates in many contexts.

3) Several studies support that response-reinforcer contingency is an essential aspect of some improvements in behavior.

4) Studies have effected changes in rates of behavior that existed prior to intervention; intervention programs increased an infrequently occurring response or brought certain behaviors under stimulus, situational, or agent control.

5) Retardates are very sensitive to reinforcement contingencies; that is, they acquire discriminations rapidly.

6) Punishment effects dramatic decreases in behavior temporarily. Birnbrauer states that

although I can think of no alternative but to apply severe punishment in some cases, I have seen nothing that has led me to change my opinion that suppression is at best only the beginning of a program of habilitation.¹¹⁵

¹¹⁵ Birnbrauer, J.S., Generalization of Punishment Effects--A Case Study. Journal of Applied Behavior Analysis, 1968, 1, 201.

7) Variables controlling such repetitive acts as self-injurious behavior remain a puzzle.

In research specific to the classroom with the mentally retarded dramatic changes in classroom behavior is effected by manipulation of response consequences. There are two problems: 1) maintenance of gains, and 2) although class behavior has been affected in impressive ways, academic learning has not been.¹¹⁶ Modeling, social reinforcement and tokens have been found effective in teaching social problem solving,¹¹⁷ motor skills,¹¹⁸ game skills and number concepts,¹¹⁹

116

Ross, S.A. Effects of Intentional Training in Social Behavior on Retarded Children. American Journal of Mental Deficiency, 1969(a), 73, 912.

117

Id.

118

Ross, S.A. Effects of an Intensive Motor Skills Training Program on Young Educable Mentally Retarded Children. American Journal of Mental Deficiency, 1969(b), 73, 920.

119

Ross, D.M. Incidental Learning of Number Concepts in Small Group Games. American Journal of Mental Deficiency, 1970, 74, 718.

listening skills,¹²⁰ and problem solving and planning.¹²¹

In an interesting study by Graubard, Rosenberg and Miller¹²² the purpose was to teach the retarded children in special classes to modify the behavior of peers and teachers. Students were taught to reinforce positive teacher response by establishing eye contact, nodding, and giving thanks for help, for example. The students' behavior in class was changed for the better through this procedure.

Individual programs and special methods have shown that even severely retarded can learn.¹²³ A review of the studies of special educational intervention for the educable and

¹²⁰ Ross, D.M. & Ross, S.A., The Efficacy of Listening Training for Educable Mentally Retarded Children. American Journal of Mental Deficiency, 1972, 77, 137.

¹²¹ Ross, D.M. & Ross, S.A. Cognitive Training for the EMR Child: Situational Problem Solving and Planning. American Journal of Mental Deficiency, 1973, 78, 20.

¹²² Graubard, P.S., Rosenberg, H. & Miller, M.B., Student Applications of Behavior Modification to Teachers and Environments of Ecological Approaches to Social Deviancy, in Ramp, E.A. & Hopkins, B.S. (eds.), A New Direction for Education: Behavior Analysis. Vol. 1. Lawrence, Kansas: The University of Kansas Support and Development Center for Follow Through, 1971, 80-101.

¹²³ Fuller, R. Breaking Down the IQ Walls: Severely Retarded People Can Learn to Read, Psychology Today, Oct. 1974, 97-100.

trainable retarded states that results are inconclusive.¹²⁴ Research is needed on the question of special classes versus integrated classes for the retarded since mainstreaming is the concept currently being put into practice. Robinson and Robinson review one of the few studies using random assignment¹²⁵ which found that all retarded children in the special classes appeared to be

somewhat better off in emotional adjustment and peer acceptance...and the group with IQs above 75 did better in regular classrooms, whereas the EMR group with lower IQs made more progress in special classes.¹²⁶

In a study by Budoff and Gottlieb¹²⁷ academic, personal and social growth were compared for a special class of

¹²⁴ Kaufman & Alberto, Research on Efficacy of Special Education for the Mentally Retarded, in Ellis, N.R. (ed.) International Review of Research in Mental Retardation, Vol. 8, 1976, supra.

¹²⁵ Goldstein, H., Moss, J.W. & Jordan, L.J. The Efficacy of Special Class Training on the Development of Mentally Retarded Children. Urbana: University of Illinois, Institute for Research on Exceptional Children, 1965.

¹²⁶ Id.

¹²⁷ Budoff, M. & Gottlieb, J. Special Class EMR Children Mainstreamed: A Study of An Aptitude (Learning Potential) X Treatment Interaction, American Journal of Mental Deficiency, 1976, 81, 1.

educable mentally retarded. One half remained in special classes and one half were placed in regular classes. After one year the integrated students were more controlled and had more positive feelings about school and themselves, indicating that the more able educable mentally retarded benefitted from integration in regular classes.

Treatment Facilities

Most research concerning treatment facilities has been done within one particular type of facility. A purpose within wards is to explore the potential of behavior modification in training self-help and social skills for the severely and profoundly retarded, and in non-residential settings to explore the behavioral training procedures and other types of therapy with the educable mentally retarded. Little has been done to compare types of treatment facilities with each other, for instance the effects of group home living versus institution.

There is a large number of studies of punishment such as seclusion, restraint, removal from the dining room, electric shock and overcorrection. The use of punishment is a major difference between the studies in wards and in other settings. This may be because the behaviors chosen to modify were those most aversive to the limited staff in wards--eating habits and toilet needs. Education, training, positive reinforcement and modeling all require considerable staff with

special skills. Time Out has also been found effective with the severely and profoundly retarded.¹²⁸ The effectiveness of procedures such as Time Out, over-correction, reinforcement and modeling need to be carefully studied considering the recent constraints on the use of shock and other aversive "therapy" or limits on primary needs (food).

McCarver¹²⁹ reviews the literature dealing with placement of the retarded in the community after institutionalization. He states that the literature is inconclusive, discrepant and contradictory, mainly unable to reliably predict who will or will not succeed on community placement because most studies were post hoc surveys. Those institutionalized for the least amount of time were more successful in all areas of community adjustment (residential stability, employment, money management, sexual adjustment and social behaviors); however, length of stay was not a variable manipulated by the experimenters. The current development of alternatives

¹²⁸ Birnbrauer, supra. "Time Out" has been defined as "contingent removal of the opportunity to earn positive reinforcement" and "contingent social isolation". Craighead, W.E., Kazkin, A.E., Mahoney, M.J., Behavior Modification, Boston: Houghton Mifflin Co., 1976, 237.

¹²⁹ McCarver, R.B. & Craing, E.M. Placement of the Retarded in the Community: Prognosis and Outcome, in Ellis, N. (ed.) International Review of Research in Mental Retardation, Vol. 7, supra, 1974.

to residential facilities underscores a need for research of these facilities and comparisons of facilities. Since the major trend is for placement into small community group homes as opposed to institutional care, the efficacy of group homes needs further evaluation. Moen, Bogen and Aanes¹³⁰ found a low failure rate (as measured by recidivism) for residents placed in group homes from institutions; fewer than 15% of these placed in group homes needed return or readmission to institutional care. In a subsequent study, Aanes and Moen¹³¹ attempt to make a more objective assessment of group homes increasing the level of functioning by using the Adaptive Behavior Scale in a pre- and post-test evaluation design, the tests being given in the group home before training and again one year later. Statistical comparisons were made for ten domains and 23 subdomains of the ABS and on three of the domains and eight of the subdomain areas there were significantly higher levels of functioning.

¹³⁰Moen, M., Bogen, D. & Aanes, D. Follow-up of Mentally Retarded Adults Successfully and Unsuccessfully Placed In Community. Hospital and Community Psychiatry, 1975, 26(11), 752.

¹³¹Aanes, D. & Moen, M. Adaptive Behavior Changes of Group Home Residents. Mental Retardation, 1976 (Aug) 14(4), 36.

EVALUATION

Measuring the success of treatment has traditionally been assumed by the mental health profession. The question of treatment itself was examined in Eysenck's 1965 study of the effects of psychotherapy on the treatment of the mentally ill. He concluded:

[p]sychoanalysis is no more successful than any other method, and that in fact all methods of psychotherapy fail to improve on the recovery rate obtained through ordinary life experience and non-specific treatment.¹³²

As will be discussed in Chapter IV, courts have now held that the mentally retarded have a right to adequate treatment. Courts and commentators frequently use the terms "adequate", "permissible", "appropriate", and "responsible" to describe the required treatment.¹³³ These terms are imprecise and courts are still faced with the applicable standard to be used. Courts have held that "adequate treatment" means each patient be given a "realistic opportunity to be

¹³²Eysenck, The Effects of Psychotherapy, International Journal of Psychiatry, 1965, 1, 99. Therapies based upon learning theories were excluded from the study, but Eysenck suggested they might be effective.

¹³³Schwitzgegel, R.K. The Right to Effective Mental Treatment, California Law Review, 1974, 62, 936.

cured or improved",¹³⁴ "show therapeutic progress",¹³⁵ or be treated under the "least restrictive alternative".¹³⁶

To determine whether or not the treatment provided at a particular institution or by a particular agency is adequate the courts must set standards and evaluate the treatment actually provided.

The right to treatment, if it is to become more than idealistic rhetoric devoid of practical social consequences, must be measured by clear standards. The courts, legislatures, treatment personnel, and attorneys must have some precise standard in mind by which they can determine whether the amount of treatment provided or not provided for a patient is an appropriate matter for legal action.¹³⁷

Thus evaluation of treatment is now a responsibility of the courts as well as mental health professionals. Courts in making their evaluations, however, rely upon the testimony of psychologists to learn the nature of mental retardation, kinds of treatment suitable for particular mentally retarded persons, and standard treatment methods. It has been suggested that a reasonable standard of treatment is

¹³⁴
Wyatt v. Stickney, supra.

¹³⁵
Jackson v. Indiana 406 U.S. 373 (1972).

¹³⁶
Welsh v. Likens, 373 F.Supp. 487, 501 (D.Minn. 1974).

¹³⁷
Schwitzgebel, R.K., Right To Treatment for the Mentally Disabled: The Need for Realistic Standards, Harvard Civil Rights--Civil Liberties Law Review, 1973, 8, 513, 515.

effectiveness.¹³⁸

To evaluate the effectiveness of treatment courts use one or more of the following criteria: 1) structure of the institution, 2) process of treatment delivery and 3) treatment outcome.¹³⁹ A structural analysis, which is the most commonly suggested approach and probably the easiest to use, includes such things as the size of the institution, staff-patient ratios and per capita costs.¹⁴⁰ For example, in Martalla v. Kelley¹⁴¹ the court examined the ratio of

138

Id.

139

Schwitzgebel.R., California Law Review, supra.

140

Schwitzgebel.R., Harvard Civil Rights--Civil Liberties Law Review, supra.Birnbaum in The Right to Treatment, American Bar Association Journal, 1960, 46, 499 suggested that courts adopt the American Psychiatric Association Standards for Hospital and Clinics which required: one physician for every 40 patients, one psychologist for every 60, one nurse for every 15, one social worker for every 35, one aid for every 2.5 patients. This has been used by the courts even though in 1969 the American Psychiatric Association revised its position and no longer required minimum ratios.

141

349 F.Supp. 575 (S.D. N.Y. 1972).

professional personnel to the patients, the training and poor communication among the personnel and the lack of information about each patient to determine that the treatment was inadequate. Rouse v. Cameron¹⁴² and Wyatt v. Stickney¹⁴³ analyzed the size of the institution, staff-patient ratios and per capita costs. In Wyatt, for example, the court found having the ratio of one physician per 5,000 patients could not provide adequate treatment.

While the criteria for evaluation and evaluation itself are relatively simple, under the structural approach a facility may be structurally adequate and still not provide effective treatment. The mere presence of a sufficient number of staff does not mean they will actually treat patients. Mere availability of treatment modalities without optimal combinations for each patient will not amount to treatment. Structural aspects concerning size, expenditure and staff training may be useful in a broad range of analyzing treatment, but not treatment outcome.¹⁴⁴

¹⁴²373 F.2d 451 (D.C. Cir. 1966).

¹⁴³334 F.Supp. 1341 (M.D. Ala. 1972).

¹⁴⁴Schwitzgebel, R., Harvard Civil Rights--Civil Liberties Law Review, supra.

The process of treatment delivery as an evaluation tool examines whether or not the treatment purportedly available at the institution is actually delivered to the mentally retarded person. This type of review was required in Wyatt where the court required treatment plans, periodic review and a record of therapy.¹⁴⁵ Use of such an evaluative tool in a Missouri study revealed that the average patient in mental health centers spent only 2.01 hours per week in traditional forms of individual and group therapy, but the average patient in state hospitals spent only .31 hours per week in these types of therapy.¹⁴⁶ A review of patients' treatment plans will show whether an effective treatment plan was implemented with direct service to the patient. While this criterion for evaluation may accurately measure delivery of services, it also has deficiencies. For example, if commonly accepted practices are inadequate, an impressive

¹⁴⁵344 F.Supp. 373, 384-385 (M.D. Ala. 1972).

¹⁴⁶Evenson, Neumenhuizen, Sletten & Cho, A Computerized Survey of Treatment Used In Missouri Institutions, Hospital & Community Psychiatry, 1973, 24, 23.

delivery record may be inconsequential.¹⁴⁷ An examination of patient records may measure the quantity of therapy, but the relationship between quantity and quality is uncertain.

A third criteria which may be used in evaluating the effectiveness of treatment is the treatment outcome approach. The question then for evaluating treatment is simply "What are the results?" Information showing the percent of patients released from the institution and recidivism rates might show the effectiveness of the institution as a whole. An effective treatment outcome evaluative tool is what has been called a contract fulfillment analysis.¹⁴⁸ Outpatients at a mental health clinic and the therapist set a treatment goal. When the treatment is concluded the patient and a follow-up worker review the contract and record the degree of fulfillment of the outlined goals.

Use of the outcome approach is the most direct and accurate in evaluating treatment. However, a recent United States Supreme Court decision leaves the viability of this

¹⁴⁷Schwitzgebel, R., Harvard Civil Rights--Civil Liberties Law Review, supra.

¹⁴⁸Lombilla, Kiresak & Sherman, Evaluating a Community Mental Health Program: Contract Fulfillment Analysis, Hospital and Community Psychiatry, 1973, 24, 760.

evaluation criterion by the courts in doubt.¹⁴⁹

Courts may use a combination of these three evaluative criteria in evaluating the adequacy of the treatment provided. These three criteria, particularly the latter, may be of value to mental health professionals as well in evaluating the adequacy of treatment given.¹⁵⁰

SUMMARY

Archaic models have inhibited acceptance of modern psychological theories for dealing with mental retardation. Much legislation and judicial opinions presuppose the validity of the archaic models. Litigation involving the right to treatment and interdisciplinary activities and publications are discrediting the archaic models.

The normalization principle is generally recognized by psychologists and those in special education and has been implemented not only in Sweden but also attempts are being

¹⁴⁹Donaldson v. O'Connor, supra, (The appellate court said that the mentally retarded had a right to such treatment as would cure or at least improve each mentally retarded's condition. The Supreme Court vacated this opinion with Chief Justice Burger in a concurring opinion indicating the courts could not require any kind of outcome.)

¹⁵⁰Moos & Schwartz, Treatment Environment and Treatment Outcome, Journal of Nervous and Mental Disease, 1972, 154, 264, found no clear relationship between staff-patient ratios and success in the communities.

made in the United States. Implementing the normalization principle will have great impact on the lives of the mentally retarded and the facilities purportedly or actually serving them. Normalization requires moving the mentally retarded out of the institution and into the community, providing therapeutic activities in sheltered workshops, integration in classrooms, residing in family-like settings, and less restriction under the law.

As will be discussed in Chapter IV, courts are now examining the treatment offered the mentally retarded and have developed standards for evaluating the treatment the mentally retarded are receiving. It is important both in the evaluative process and in the delivery of services to recognize that treatment is an ongoing process affected by the total environment. It has been suggested that behavioral procedures for the mentally retarded have as specific objectives:

- 1) to increase competence to cope with the environment;
- 2) to foster increasingly more complex adaptive behavior, and
- 3) to enhance human qualities.¹⁵¹

151

Guidelines for the Use of Behavioral Procedure in State Programs for Retarded Persons, Monograph, Arlington, Texas: National Association for Retarded Citizens, 1976.

CHAPTER III

LAW AND THE MENTALLY RETARDED; AN OVERVIEW

The development of the law as it affects the rights of the mentally disabled has been dependent on three factors: 1) the extent of medical knowledge on cause, care and proper treatment of the mentally disabled; 2) the degree to which the politically organized community has acknowledged its responsibility for the care and treatment of its afflicted citizens; and 3) the legal profession's awareness of the social realities of mental disability, as well as the acuteness of its concern for those who neither have relatives nor close friends to safeguard their rights.¹⁵² In each of these areas, there are new interests or developments in mental retardation, which make mental retardation a contemporary inter-disciplinary issue; 1) research with the mentally retarded, discussed in Chapter II, is revealing a new picture of retardation in a developmental model; 2) society seems

¹⁵²

Brackel & Rock, *supra*.

ready to participate in the problems of the retarded;¹⁵³ and
3) the courts and legislatures are resolving legal rights.

Recent developments in securing the rights of the mentally retarded to habilitation have been the result of increased scientific understanding of mental retardation and recognition that ancient legal restrictions and definitions are inconsistent with this new understanding. Progress is being made to establish a legal right to treatment, but prerequisite to sustained legal rights is increased public and professional education of the great developmental potential of the mentally retarded. The change is sometimes slow due to a long history of misconceptions regarding mental retardation. Conflicts in theory, laws, and treatment practices have resulted in the modern treatment controversies.

Historical traditions, stereotypes and beliefs concerning mental retardation, and desires of legislators and judges to assist the mentally retarded while protecting society have resulted in laws specifically for the mentally retarded.¹⁵⁴ These special rules include; 1) civil commitment;¹⁵⁵

¹⁵³See pages 19-21 for a discussion of four organizations. Additional organizations are enumerated and discussed in Gearheart & Litton, *supra*.

¹⁵⁴Kindred, Cohen, *supra*.

¹⁵⁵ORS Chapt. 427.

2) legal incompetency;¹⁵⁶ 3) guardianship or conservatorship to manage the daily financial and personal affairs of the person;¹⁵⁷ 4) criminal law;¹⁵⁸ 5) restrictions on community rights such as entering into any contract,¹⁵⁹ making a will,¹⁶⁰ bringing civil suits,¹⁶¹ obtaining a driver's license, testifying in court as a witness and serving as a juror;¹⁶² and 6) restrictions on personal rights and family life such as sterilization, annulment of marriage and involuntary adoption of his children.¹⁶³ The areas of law enumerated above as they impinge upon the personal liberty of the mentally retarded are discussed in this chapter.

¹⁵⁶
Id.

¹⁵⁷
ORS Chapt. 126.

¹⁵⁸
ORS Chapt. 161.

¹⁵⁹
Gindhart v. Skourtes, 271 Or. 115, 530 P.2d 827 (1975).

¹⁶⁰
ORS Chapt. 112.

¹⁶¹
Mullen v. Bruce, 168 Cal.App. 2d 494, 335 P.2d 945 (1959).

¹⁶²
See ORS 482.120 regarding driver's license.

¹⁶³
ORS 109.310.

he will be committed,¹⁶⁶ In actual practice the involuntary commitment procedure for the mentally deficient is rarely used.¹⁶⁷

Once the actual decision to commit is made the mentally deficient person remains in the facility except for any leaves of absence. The person is re-examined some time after commitment to determine whether he should remain. The mentally ill person may be committed for a period not to exceed

¹⁶⁶ORS 427.062. The statutes relating to involuntary commitment of the mentally ill contain more procedural requirements including appointment of an attorney unless expressly waived; the mentally ill person will be committed if mentally ill and in need of treatment, care or custody because he suffers from a mental disorder and is dangerous to himself or others or is unable to provide for his basic personal needs. there will be at least two hearings and unlike the mentally retarded person who is simply told that he has the right to be represented by an attorney the judge will appoint an attorney to represent the mentally ill person "unless counsel, is expressly, knowingly and intelligently refused by the person." ORS 426.100(2). Strict proof is required showing that the person is dangerous to himself or others or unable to provide for his basic needs before he may be committed. State v. O'Neil, 274 Or. 59, 545 P.2d 96 (1976).

¹⁶⁷Statistics show only one in Multnomah County, Oregon for the year 1976. (Multnomah County Probate Court, telephone conversation, DEC., 1976). The majority of those mentally retarded who are committed are committed "voluntarily" while they are minors by their parents. The mentally ill-mentally retarded categories are not mutually exclusive and in Oregon many go through the commitment procedures for the mentally ill because it is simpler. Inter-institutional transfer is not difficult and the mentally retarded individual may then be transferred after being committed. (Interview with Jeffrey S. Mutnick, formerly with Multnomah County Public Defender's Office, Jan. 5, 1976).

CIVIL COMMITMENT

In Oregon, involuntary commitment of the mentally deficient may be commenced by "any citizen" filing a petition with the county probate judge. The petition must allege that the person who is the subject of the petition is mentally deficient and in need of care, custody or training.¹⁶⁴ The judge then examines the petition and observes the person personally at a hearing. If after "viewing" the person and reviewing the petition, the judge thinks that the person is in need of care, custody or training, the judge orders a precommitment mental and physical examination at Fairview Training Center in Salem or some other suitable institution.¹⁶⁵ The person must be examined in seven days and findings of deficiency and recommendations forwarded to the court within 30 days. The court conducts another hearing after receiving the recommendations. If the court determines the person is mentally deficient and in need of care, custody or training

¹⁶⁴

ORS 427.015. (Present statutes use the term mentally deficient. SB 79 introduced in the 1977 Oregon Legislature substituted the term mentally retarded for mentally deficient among many other changes. The bill, however, never got out of committee.)

¹⁶⁵ ORS 427.025.

180 days,¹⁶⁸ He will only be held beyond that period if the treating facility certifies to the judge that the person is still mentally ill. The mentally ill person may protest and have a hearing before the judge. If he is found mentally ill he will remain in the institution, but again only for 180 days unless the above procedure is followed.¹⁶⁹

A person may voluntarily seek admission to a mental health facility,¹⁷⁰ but many question whether for the mentally deficient person, asking for commitment is ever voluntary.¹⁷¹ In the case of a minor or incompetent person, the admission, even though termed "voluntary" may not be voluntary, because the application must be made by the parent or person entitled to custody.¹⁷² Whoever makes the application, the person thought to be mentally retarded is examined at the mental health facility and admitted if found in need of care, custody or training. The person who is voluntarily admitted as a

¹⁶⁸ORS 426.130.

¹⁶⁹ORS 426.301.

¹⁷⁰ORS 427.210-260.

¹⁷¹Kindred, Cohen et al., supra.

¹⁷²ORS 427.220.

minor whether mentally ill or mentally retarded by his parents will be examined by a physician and psychologist and based upon their report will either be released or committed as an involuntary patient.¹⁷³

Once admitted the mentally deficient person can be released only upon 30 days written notice unless the facility successfully petitions the court to have the person's status changed from voluntary to involuntary.¹⁷⁴ The notice must indicate the proposed future treatment plan. There are several discrepancies between the rights afforded the mentally deficient and mentally ill in Oregon: one of these is the voluntarily admitted mentally ill patient can be released in 72 hours of his request unless his status is changed through the courts from voluntary to involuntary.

LEGAL INCOMPETENCY

Voluntary admission or involuntary commitment to a mental health facility does not mean that the person is

¹⁷³ ORS 427.250, Bartley v. Kremens, 402 F.Supp. 1039 (E.D. Pa. 1975).

¹⁷⁴ ORS 427.225-240.

legally incompetent.¹⁷⁵ If a judge finds a committed person incompetent, a guardian will be appointed for the person. In addition, the person will be unable to enter into a contract, make a will, or obtain a driver's license.¹⁷⁶ Any subsequent marriage may be annuled as well.

Procedural requirements must be followed before a person is found incompetent because the person suffers a serious loss of liberty even beyond commitment. First, a hearing instigated by the person, his guardian, relative or creditor, or other interested person, must be held before the probate judge.¹⁷⁷ The person must appear and be informed of his right to an attorney and subpoena witnesses. The judge will appoint an attorney to represent him unless the person "expressly, knowingly and intelligently refused legal counsel."¹⁷⁸ The

¹⁷⁵ORS 427.305. "Incompetency" is not defined; however, statutes relating to appointment of a guardian define an "incapacitated person as one "who is unable, without assistance, to properly manage or take care of himself or his personal affairs." ORS 126.003. Presumably, a similar standard would be used to determine incompetency.

¹⁷⁶Each of these is discussed later. A person may not be able to do any of the things listed even though not found legally incompetent.

¹⁷⁷ORS 427.310.

¹⁷⁸Id. (It would seem that when competency is at issue legal counsel would be necessary since one might not be in a position to intelligently and knowingly refuse.)

court may appoint any private physician to examine the mental condition of the person.¹⁷⁹

When the mentally ill or mentally retarded person is released from the mental health facility, he will be found competent if the chief medical officer believes him to be. If not, the mentally retarded person, his guardian, relative, creditor, or other interested person, may petition the court for a hearing.¹⁸⁰ If he is still found incompetent, the guardian will remain and the other restrictions outlined earlier will continue until or if a legal designation of competency is restored.

GUARDIANSHIP

A guardian or conservator may be appointed for any person including the mentally deficient person without any legal finding of incompetency required. A guardianship is created for the protection of the person's property. To have a guardian appointed the judge must find the person incapacitated (Unable to take care of himself or his personal affairs) and the appointment of a guardian is necessary or desirable

¹⁷⁹
ORS 427.325.

¹⁸⁰
ORS 427.310(3).

as a means of providing continuing care and supervision of the person.¹⁸¹ The procedure commences by the incapacitated person, or any person interested in his welfare, petitioning the probate court for appointment of a guardian. If anyone objects to the petition, the court will appoint an attorney to represent the alleged incapacitated person, a physician to examine the person, and an officer, employee or appointee to the court to interview the person and prepare a report. If objections to the petition are raised, the person may be present at the hearing to hear or see evidence relating to his condition, and may through his attorney present evidence, and cross-examine the witnesses including the court appointed physician and interviewer. If requested the hearing will be closed to the public.¹⁸²

The guardian may be any person qualified and willing to serve, but the court gives preference to relatives and to persons requested by the incapacitated person in writing while he was competent.¹⁸³ A guardian so appointed remains the guardian of the person until the guardian or the ward (the

¹⁸¹ORS 126.107.

¹⁸²ORS 126.103.

¹⁸³ORS 126.035.

incapacitated person for whom the guardianship was created): 1) dies, 2) becomes incapacitated, 3) is removed or resigns, or 4) the court orders that the incapacity no longer exists.¹⁸⁴ Once appointed, the guardian acts as a parent of the ward. He may have custody, arrange for training and education, take care of the ward's personal property, consent to medical and professional care and dispose of the ward's property to meet limited expenses unless a conservator has been appointed.

Appointment of a conservator is similar to appointment of a guardian. A conservator may be appointed to manage a person's property if the court finds he is unable to manage his property and affairs effectively because of mental illness or mental deficiency and has property or money in need of management. If the mentally deficient person has no friends or relatives willing to serve as guardian or conservator and the Board of County Commissioners determines one should be appointed, a public guardian and conservator may be appointed by the court under the same procedures discussed above.¹⁸⁵

Guardianship is intended to protect a person who cannot care for himself. The statute does not provide for an examination or even interview by a person trained in psychology. The guardian, who may be a relative, is to provided for

¹⁸⁴ORS 126.137.

¹⁸⁵ORS 126.905, 126.925.

the education and training of the mentally deficient person. There is no provision for professional assistance in selecting the appropriate training or education for the individual. If rehabilitation or habilitation is the goal, the statutes should specifically provide for professional assistance in selection, training and education. A conservatorship is less for the benefit of the incapacitated person than for the children, creditors and even the state to whom the person may be indebted. It is designed to protect the assets of the person and to see that his needs are met financially. Two problems exist: 1) the statute states that the court must find that the person cannot effectively manage his affairs, but does not offer further explanation; and 2) again no provision is made for examination or interview by a person trained in psychology. Few individuals manage financial affairs as effectively as possible. Unwise investments are made and unnecessary goods and services are bought. Furthermore, management of financial affairs, however ineptly, may result in a sense of accomplishment encouraging self-reliance or perhaps the seeking of additional training.

A serious question as to the advisability of a guardianship exists when the advice and provision of social services would serve as well.¹⁸⁶ In many cases limited guardianship or

¹⁸⁶

Kindred et al., supra.

conservatorship with less restrictive controls, giving the ward or protected person an opportunity to participate to the fullest extent possible in the decisions affecting his life and property may be more effective than the traditional forms.

CRIMINAL LAW

In Oregon criminal law, a person may not be legally guilty of criminal conduct because: 1) a mental disease or defect causes him to lack sufficient mental capacity to appreciate the criminality of his conduct or 2) a mental disease or defect prevents him from conforming his conduct to the requirements of the law.¹⁸⁷ If the criminal defendant is found not guilty by reason of mental disease or defect he may be committed to a mental health facility. He will be committed if he: 1) is still affected by mental disease or defect at the time of the hearing, 2) is a danger to himself or others, and 3) would not be a proper subject for release or supervision by a person appointed by the court, the Oregon Mental Health Division or a community mental health program.¹⁸⁸

A person may be committed without a finding by the court or jury that he is not guilty because of a mental disease or defect if he is found incompetent to appear before

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ORS 161.295(1).

¹⁸⁸

ORS 161.340.

the judge or jury for trial.¹⁸⁹ If the person later becomes competent he may be tried for the crime unless at least five years have elapsed from the time of the court's finding of incompetency and he has been committed to a mental health facility during this five year period.¹⁹⁰ A trial would be unjust after five years.

A person who has been committed as the result of criminal law proceedings may be discharged if any of the following three things occur: 1) at any time after admission to a state mental health facility, the superintendent after examining the person is of the opinion that the person is no longer affected by a mental disease or defect, or if still affected no longer presents a substantial danger to himself or others; 2) after 90 days of custody the person, whether mentally ill or mentally deficient, successfully applies to the circuit court for discharge on the grounds stated in (1) above; or 3) after five years of custody, unless the court finds he is still affected by a mental disease or defect and is a substantial danger to himself or others.¹⁹¹

¹⁸⁹ ORS 161.360. A person is incompetent to stand trial if he is unable (a) to understand the nature of the proceedings against him; or (b) to assist and cooperate with his counsel; or (c) to participate in his defense.

¹⁹⁰ ORS 161.370

¹⁹¹ ORS 161.340, 161.350.

The court must conduct hearings to determine whether or not the person still suffers from a mental disease or defect, or if so affected does not present a substantial danger to himself or others unless the superintendent of the mental health facility files a report recommending discharge and the state does not object.¹⁹² At the hearing psychiatrists and psychologists will be called upon to examine the person and testify concerning his condition.

RESTRICTIONS IN THE COMMUNITY

The mentally retarded or the mentally ill person may be unable to enter into a contract, make a will, bring a civil suit or obtain a driver's license. In most states a contract which a mentally deficient person has entered into may be voided if there is an inadequate consideration, fraud, or a lack of good faith.¹⁹³ In Oregon, a contract a mentally incompetent person has entered into may be voided if the person is incompetent to transact business and the contract is grossly unfair.¹⁹⁴ For the non-retarded a contract may not be avoided simply because it is unfair.

¹⁹² ORS 161,345.

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Allen, R.C., Feister, E.Z. & Weinhofen, H., Mental Impairment and Legal Competency, Englewood Cliffs, New Jersey: Prentice-Hall, 1968.

¹⁹⁴

Gandhart v. Skourtes, 271 Or. 115, 530 P.2d 827 (1975)
Scovil v. Barney, 4 Or. 288 (1872) (A mentally deficient person who deeded property to another for less than its value was entitled to have his property returned because of incompetency.)

What constitutes the requisite competency is left to the discretion of the judge in each case. Mental capacity to enter into a contract requires that the person has ability to comprehend the nature of the transaction. However, mere dullness of intellect, ability to be easily influenced and dependency upon others does not make the person incompetent. The question is not whether the person understood the contract, but was capable of understanding it.¹⁹⁵

To make a valid will the person must be of sound mind at the time he makes the will.¹⁹⁶ If the will of a person is challenged on the ground that the testator, the person who made the will, was not of "sound mind" at the time, the court will consider whether the person: 1) comprehended the nature of the act in which he was engaged; 2) knew the nature and extent of all of his property at the time; 3) had in mind

195

Kruse v. Coos Head Timber Co., 248 Or. 294, 432 P.2d 1009 (1967) (Person unable to read some words in contract.. with 83 I.Q., fifth grade performance level and easily influenced but who had been employed in manual labor was found to be of normal, although below average intelligence and, therefore, competent to enter into contract.)

the persons who were, should, or might be, the objects of his bounty; and 4) was cognizant of the scope and provisions of his written will.¹⁹⁷ A person may be in a state of "extreme imbecility" and yet possess sufficient understanding to direct how his property should be disposed.¹⁹⁸

The person who made the will is presumed to have been of sound mind unless he had a guardian at the time he made the will. If he had a guardian, there is a presumption that he lacked the mental capacity to execute a will.¹⁹⁹ That presumption may be overcome by testimony of persons seeking to enforce the will.²⁰⁰ In a recent Arizona case²⁰¹ a testator functioning at a mental level of 10-12 years but able to do simple tasks and drive a car was found to have necessary

¹⁹⁷
Vsetecka v. Novak, 4 Or.App. 463, 478 P.2d 655 (1970).

¹⁹⁸
Chrisman v. Chrisman, 16 Or. 127, 18 Pac. 6 (1888).

¹⁹⁹
In re Provolt's Estate, 175 Or. 128, 151 P.2d 736 (1944).

²⁰⁰
Whittenberry v. Whittenberry, 9 Or.App. 154, 496 P.2d 240 (1972) (Decedent who two months before he made his will had been found incompetent by an examining psychiatrist, was found competent to make a will based on the testimony of lay witnesses to the signing of the will that he seemed normal.)

²⁰¹
In re Teel's Estate, 14 Ariz.App. 371, 483 P.2d 603 (1971).

capacity to execute a will. While the capacity level required to make a will is low, litigation contesting the validity of a mentally disabled person's will may dissipate the estate and, the will may be found invalid. To help avoid litigation it may be advisable for the possibly mentally retarded person to be examined by a psychologist just prior to executing his will. Knowing that a psychologist will testify as to the person's competency will discourage most people from contesting the will. Of course, except for money obtained through inheritance and somehow not expended for care or treatment, the mentally retarded person with a substantial estate is rare.²⁰²

The mentally deficient person may sue and be sued in civil cases for most torts. He may not be sued for torts requiring malice or intent.²⁰³

Even if it is deemed incongruous to hold an insane person liable in damages for an injury inflicted by an act which his infirmity rendered impossible to restrain, it is reasonable to hold the insane person liable under the principle that when one of two innocent persons must suffer a loss, it should be borne by the one who occasioned it.²⁰⁴

Unless the mentally retarded person has been adjudged incompetent or placed under a guardianship, he may sue or be

²⁰² Kindred et al., supra.

²⁰³ Asch, supra.

²⁰⁴ 41 Am.Jur. 2d, Incompetent Persons §104. Rochester, New York: Lawyer's Cooperative Publishing Co., 1967.

sued in his own name.²⁰⁵ If either of the above has occurred the mentally deficient may sue or be sued through his guardian. If he is incompetent to bring or defend an action, a guardian will be appointed ad litem (for the sole purpose of bringing or defending the action).²⁰⁶

The mentally deficient person may bring an action or defend one but be unable to testify in his own behalf at trial if he is of unsound mind.²⁰⁷ Those mental defects which interfere with the ability to perceive and communicate disqualify a witness as being incompetent to testify .

A person who has been committed to a state institution for the mentally deficient and found mentally retarded cannot obtain a driver's license.²⁰⁸ Even if he has not been committed or found mentally deficient, he may be denied a driver's license if the Oregon Motor Vehicle Division determines that the person is suffering from mental disability which prohibits his operation of a motor vehicle or his understanding of highway signs.²⁰⁹

²⁰⁵ Id.

²⁰⁶ ORS 13.051.

²⁰⁷ ORS 44.030.

²⁰⁸ ORS 482.120(2).

²⁰⁹ ORS 482.130.

Under Oregon Motor Vehicle Division regulations, persons applying for a driver's license must take a written examination and demonstrate to an examiner competency to operate a motor vehicle. If the person appears to the division "to be affected with or suffering from any physical or mental disability or disease which might affect his operation of a motor vehicle," the applicant may 1) be required to demonstrate personally that notwithstanding such disease or defect he is a proper person to operate a motor vehicle, 2) be required to submit to an examination by the State Health Officer who reports to the division the results of the examination, 3) have his physician send a report to the State Health Officer and 4) ²¹⁰ be examined by a specialist designated by the division.

The major difficulty with the statutes and accompanying regulations is that they leave to the discretion of state employees in the Motor Vehicle Division whether or not the person appears to be suffering a mental disability. As a consequence a person whom a psychologist might find only a borderline retarded, fully competent to drive an automobile, may be required to obtain various reports and submit to various examinations not required by other applicants.

RESTRICTIONS ON PERSONAL RIGHTS AND FAMILY LIFE

The mentally deficient person may also have restrictions placed upon his personal rights and family life by being sterilized, having his marriage annuled, and having his children adopted against his will. With the discovery of the vasectomy as a relatively safe method of sterilization in the 1920's statutes authorizing sterilization were adopted in many states.²¹¹ Challenges to the constitutionality of the statutes were rejected,²¹² and they continue to exist in most states.²¹³ Under Oregon law a mentally deficient person may be sterilized to prevent procreation.²¹⁴ He is entitled to a hearing where he may be represented by an attorney.

²¹¹Brackel & Rock, supra.

²¹²Buck v. Bell, 274 U.S. 200 (1927) (A mentally deficient 18 year old woman who was the daughter of a mentally deficient mother and who had a mentally deficient child herself unsuccessfully challenged a statute under which a judge ordered her sterilized. In holding that the statute did not violate the woman's right to due process as guaranteed by the Fourteenth Amendment of the United States Constitution, Justice Holmes stated, "three generations of imbeciles are enough."

²¹³Brackel & Rock, supra.

²¹⁴ORS 436.050, 436.070. Cook v. State, 9 Or.App. 224, 495 P.2d 768 (1972) (Evidence that 17 year old girl had a history of severe emotional disturbance, indiscriminate and impulsive sexual involvements while in state hospital, and brain damage making her condition unstable despite medication supported determination that sterilization was warranted.)

From 1940 to 1960 Oregon was one of the six states that averaged more than 15 sterilizations per year. In most states except for North Carolina which involuntarily sterilized 240 people in 1963 alone, the number of mentally deficient sterilized were much lower.²¹⁵ Today the number of involuntary sterilizations in Oregon and other states are even lower. However so-called "voluntary" sterilization as a condition for release from an institution or to avoid being sent there in the first place is more frequent.²¹⁶ Sterilization of person who are receiving benefits under federally funded programs is not permitted unless the sterilization is voluntary.²¹⁷

The propriety of using sterilization as a means of reducing the number of mentally deficient persons has been challenged on the grounds that heredity is not the primary cause of mental deficiency. Birth injuries and thyroid deficiencies may also cause mental deficiency.²¹⁸ Requiring states to furnish sex education and access to contraceptive devices to all of its citizens has been suggested as a

²¹⁵Brackel & Rock, *supra*.

²¹⁶Kindred et al., *supra*.

²¹⁷Relf and Human Rights Organization v. Matthews, 403 F.Supp. 1234 (D.D.C 1975).

²¹⁸Brackel & Rock, *supra*. See also the etiology of mental retardation discussed in Chapter II.

alternative to statutes permitting involuntary sterilization and reducing the number of "voluntary" sterilizations.²¹⁹

A mentally deficient person may have his marriage annulled. Procedurally, an action to have the marriage annulled is brought by the filing of a petition for annulment on the ground that one or both of the parties was incapable of making the contract or consenting to it "for want of legal age or sufficient understanding."²²⁰ The marriage then becomes void when it is declared void by the court.²²¹ To warrant an annulment there must be insufficient mental capacity to comprehend the nature and consequences of the business in which the party was engaged, as required in other contracts.²²²

It has been suggested that if a state wishes to enforce its prohibition against the marriage of the mentally deficient,

²¹⁹Kindred et al., supra. It is questionable whether the agreed sterilization of a person desiring federal or state aid or to avoid institutionalization is in fact "voluntary," since it is agreed to under what could amount to duress or may not be agreed to by the parent or guardian of the person and not the person himself.

²²⁰ORS 107.105(1).

²²¹ORS 106.030.

²²²Coleman v. Coleman, 85 Or. 99, 166 P. 47 (1917).

it should use something other than annulment, such as checking applications for a marriage license against a central record for all incompetent or hospitalized persons or requiring a physician's statement.²²³ Under the current system mentally retarded persons in similar circumstances may be treated unequally, and the annulment, which may not be granted until several years after the marriage, always occurs after the fact. Others have suggested that in our present state of knowledge, there is no data to justify application of a different rule to mentally deficient persons. The risk of marriage ending in failure is applicable to all persons, mentally deficient or not.²²⁴

In Oregon the child of a mentally deficient person may be adopted by another even though the mentally deficient person does not consent to the adoption.²²⁵ Procedurally, any person seeking to adopt a child petitions the court for an adoption order.²²⁶ If a natural parent has been found incompetent as discussed above and remains so at the time of

²²³

Brackel & Rock.

²²⁴

Kindred et al., supra.

²²⁵

ORS 109.322.

²²⁶

ORS 109.310.

the adoption proceedings, a citation is served upon his guardian if he has one. The citation orders him to appear in court at a certain time to show cause why the adoption of the child should not be decreed. A hearing is held and if the court finds that the "welfare of the child will be best promoted through the adoption of the child," the adoption will be decreed even though the mentally ill or mentally deficient person objects to the adoption. If the natural parent has not been adjudged mentally ill or deficient, no adoption will be decreed without his consent. Consequently where one of the parents is mentally ill or mentally deficient, but has not been decreed by a court to be so, and the parent does not consent to his child's adoption, the prospective adoptive parent must bring an action to have the parent decreed incompetent because of mental illness or deficiency before proceeding.

The rule permitting adoption of a mentally deficient parent's child without his consent has been criticized. There is no data to support a general finding that retarded parents are bad parents,²²⁶

Intellectual retardation is just one of the reasons for personal incompetence within the areas of family life and child-rearing, but is one of the high-risk groups in which the incompetence tends to persist over long periods of time. When one looks around

and sees the number of children who are under the care of non-retarded persons who are incompetent to the task, living in squalor, ignorance and suffering, one wonders whether the principle outlined here for dealing with the retarded do not apply equally as well to us all.²²⁷

Traditional views of what is proper parental behavior to meet the best interests of the child may be inappropriate.²²⁸

The noninstitutionalized mentally retarded have some protection in employment and utilization of public accommodation and amusement in Oregon.²²⁹ For example, it is unlawful to refuse to hire a person because he has a mental handicap unless it prevents the performance of the work involved.²³⁰ The federal government has an Interagency Committee on Handicapped Employees to encourage employment of mentally disabled persons in federal agencies or federally funded projects.²³¹ Some have suggested that the federal government

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Brackel & Rock, supra.

228

Batt, J., Child Custody Disputes: A Developmental Psychological Approach to Proof and Decisionmaking, Willamette Law Journal, 1976, 12, 491.

229

ORS 659.352, 659.425.

230

ORS 659.425(1).

231

29 USC § 791.

insure the economic security of the mentally retarded by making direct payments to them;²³² however, it is perhaps of equal importance that a person experience well being from having a meaningful, satisfying job with opportunities for training and advancement.²³³

In Oregon mentally retarded children must be provided special education.²³⁴ However since placement in a special class or schools carries a stigma²³⁵ courts have held that procedural safeguards of notice and hearing to determine that the educational placement will benefit rather than harm the child must be satisfied.²³⁶

²³²Kindred et al., supra.

²³³Farber, B., Mental Retardation, Its Social Context and Social Consequences, Boston: Houghton, Mifflin Co., 1968.

²³⁴ORS 343.221. Education is the principal method for the mentally retarded to achieve habilitation (defined in Chapter II). There is a growing body of litigation and legislation concerning education for the mentally retarded. Except for a brief review, this paper will not examine education for the mentally retarded. Court decisions have treated treatment and education separately despite their close relationship.

²³⁵Kindred et al., supra.

²³⁶Pennsylvania Association for Retarded Children v. Pennsylvania, 343 F.Supp. 279 (E.D. Pa. 1972).

Preference must be given to placement in the regular classroom with appropriate ancillary services rather than placement in a special class.²³⁷ In Larry P. v. Riles,²³⁸ the court held that students wrongfully placed in classes for the mentally retarded were irreparably harmed. Consequently the school had to show that its placement based on I.Q. test scores was rationally related to the purpose of segregating students according to their ability to learn. It has been suggested that the school have the affirmative duty of notifying parents 1) of the specific learning problem, 2) the reasons for the determination that the child cannot be successfully served in the regular classroom, 3) the results of any medical, psychological and educational assessment of the child, and 4) the specific educational plan for the child. Periodic review of the child's progress should be given to the parents. If the parents believe the classification is erroneous, they should be entitled to a hearing.²³⁹ The Oregon Department of Education has promulgated rules requiring notice to parents,

²³⁷Mills v. Board of Education for the District of Columbia, 348 F.Supp. 866 (D.D.C. 1972).

²³⁸343 F.Supp. 1306 (N.D. Cal. 1972).

²³⁹Kindred et al., supra.

a hearing, and representation by an attorney to satisfy the requirements suggested by the courts.²⁴⁰ This kind of individual analysis with its concurrent program designed to meet the specific needs of the child could be provided every child.

SUMMARY

As this chapter indicates, the law imposes a considerable influence on the lives of the mentally retarded whether institutionalized or not. In addition to commitment, the mentally retarded may have his personal decisions delegated to an appointed guardian or conservator, his contracts voided, his will disregarded, his marriage annulled and his children adopted against his will. All restrictions have a long history. Recently legislatures have adopted statutes requiring that certain procedures be followed before these restrictions may be imposed, particularly for involuntary commitment and in criminal law proceedings.

Throughout its long history of involvement, the law has been concerned with restricting the mentally retarded for the protection of the mentally retarded and society. But there has been no legal provision for providing the mentally retarded with concomitant treatment so the restrictions

may be removed or at least alleviated. Prohibitions against discrimination in employment and the right of children to special education have been recent statutory developments which show a growing concern for the rights of the mentally retarded.

Recent legislation and judicial opinions have indicated a right to treatment/habilitation for the institutionalized. The legal arguments for the right as raised by disgruntled patients or their guardians in litigation based on constitutional and statutory provisions are numerous. There is no national consensus by the courts, however, on the legal basis for a mentally retarded person's right to treatment or even if such a right exists. In the following chapter, an analysis of the right to treatment and its appropriateness for judicial review will illustrate the current status of the right to treatment for the habilitation of the committed mentally retarded. The law's deprivation of the liberty of the mentally retarded who have not been committed to a mental health facility would suggest that treatment or habilitation should be afforded them as well.

CHAPTER IV

THE RIGHT TO TREATMENT

The right to treatment as that term is used by legal writers and judges is in reality a right to habilitation.

Habilitation has been defined as:

the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of this physical, mental, and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.²⁴¹

In the law, especially judicial opinions, there must be more than a theoretical right to habilitation. There must be some legal basis for the right or it will not be enforced. Furthermore, merely the existence of a legal basis for treatment is not enough to activate judicial involvement. The controversy must be justiciable--capable of judicial review. Once those two preliminary requirements have been satisfied courts are

²⁴¹Wyatt v. Stickney, 344 F.Supp. 387, 395 (M.D. Ala. N.D. 1972). See Chapter II for a discussion of the normalization principle which is generally used by psychologists rather than habilitation which is used by the courts.

then in a position to evaluate the adequacy of the treatment afforded.

BASES FOR THE RIGHT

There are several legal bases justifying the right to treatment: 1) the Fourteenth Amendment; 2) the Eighth Amendment; 3) the Thirteenth Amendment; 3) statutes such as the Federal Civil Rights Act; and 4) a state's liability to the mentally retarded for money damages in negligently failing to provide treatment or in breaching its agreement to provide treatment.

Fourteenth Amendment

One basis for treatment recognized by the court in Wyatt²⁴² is due process and equal protection as provided in the Fourteenth Amendment:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the law.²⁴³

²⁴²Wyatt v. Stickney, 344 F.Supp. 373 (M.D. Ala. N.D. 1972) aff'd sub. nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Circ. 1974). See also James v. Wallace, 406 F.Supp. 318 (M.D. Ala. 1976); Welsh v. Likens, 373 F.Supp. 487 (D.Minn., 1974); Davis v. Watkins, 384 F.Supp. 1196 (N.D. Oh. 1974); But see Donaldson v. O'Connor, 422 U.S. 957 (1975).

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U.S. Const., amend. XIV.

The amendment does not specifically provide for treatment nor even mention the mentally retarded. The courts in decisions which have been decided in various contexts²⁴⁴ have held that the Fourteenth Amendment requires that the mentally retarded receive treatment. Essentially the amendment requires that no state deprive any person of life, liberty or property without due process of law. Courts have held that due process may be divided into procedural due process and substantive due process. Procedural due process requires that certain formalities such as a hearing before a judge, testimony by witnesses with the opportunity for the opposing side to cross-examine the witnesses and representation by an attorney at all significant stages of the proceeding, be complied with before any person be deprived of life, liberty or property.²⁴⁵ Substantive due process requires that no person be deprived of his life, liberty or property for arbitrary reasons. There must be a legitimate state interest which applies even-handedly to all affected persons,²⁴⁶ and

²⁴⁴The mentally retarded may join with others similarly situated in bringing a class action or as an individual acting directly or through a guardian. The action may be for money damages, for an injunction to obtain a court order requiring treatment or seeking release from the mental health facility under a writ of habeas corpus.

²⁴⁵In re Gault, 387 U.S. 1 (1966); Bartley v. Kremens, supra.

²⁴⁶16 Am. Jur. 2d, Constitutional Law § 550 (1964).

a reasonable relationship between the deprivation and the person.²⁴⁷

Procedural due process

Application of the Fourteenth Amendment was historically restricted by the courts to adult defendants in criminal actions. Courts ruled that due process required a prompt hearing before a judge and representation of the accused by an attorney at all significant stages of the proceedings.²⁴⁸ Procedural due process requirements were subsequently extended to include juvenile offenders.²⁴⁹ The courts reasoned that since the criminal defendant, whether adult or juvenile, faced a deprivation of liberty, due process required that the accused's liberty not be taken away without a fair hearing.

Recent cases have extended procedural due process requirements to the mentally retarded who are faced with involuntary commitment to a state mental health facility. In Heryford v. Parker, 396 F.2d 393 (10th Circ. 1968) the

²⁴⁷Halpern, C.R., The Right to Habilitation, in Kindred et al., supra.

²⁴⁸Gideon v. Wainwright, 372 U.S. 335 (1963) (Criminally accused felon has a right to be represented by an attorney at all significant stages of criminal proceedings); Argersinger v. Hamlin, 407 U.S. 25 (1972) (Right to Counsel must be exercised whenever any form of imprisonment may be imposed.)

²⁴⁹In re Gault, supra.

court held that a mentally deficient person was entitled to be represented by an attorney at commitment proceedings and to confront witnesses. Parker was committed in 1946 when he was nine at the request of his mother. He remained there continually until 1963 when he was released to the custody of his parents. Against the wishes of both Parker and his parents, Parker was returned to the training school for the mentally deficient in Wyoming in 1965. He remained there until 1968. At the time of the initial commitment in 1946 the state was represented by the county prosecuting attorney and a hearing was held where the prosecuting attorney, the certifying psychologist and the mother were all present. At no time was Parker represented by an attorney. In holding that Parker's due process rights were violated by his lack of representation by an attorney the court stated:

It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration--whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent--which commands observance of the constitutional safeguards of due process.²⁵⁰

In Bartley v. Kremens²⁵¹ the federal court held that the Pennsylvania Mental Health and Mental Retardation Act of

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396 F.2d at 396.

²⁵¹

402 F.Supp. 1039, supra.

1966 and regulations developed by the Mental Health Department, which set out procedural requirements for the voluntary admission of minors, were unconstitutional. The three judge court determined that the due process clause of the Fourteenth Amendment required that minors who were "voluntarily" committed to mental health facilities were entitled to: 1) a probable cause hearing prior to commitment; 2) a post-commitment hearing; 3) written notice of all hearings; 4) representation by an attorney at all significant stages of commitment; 5) personal presence at all hearings; 6) commitment only upon a finding by clear and convincing proof of need for institutionalization; and 7) the right to confront and cross-examine witnesses and to offer testimony of witnesses.²⁵²

Bartley was appealed to the U.S. Supreme Court. On May 16, 1977 the Supreme Court vacated the lower court's decision and remanded the case for further hearings because of the changes in Pennsylvania statutes and regulations since the time of the lower court trial. Despite the Supreme Court's refusal to act, the initial opinion shows the extension of procedural due process in the commitment of the mentally retarded. Legislatures, aware of the various court decisions, have provided for certain procedures before commitment. In Oregon, however, these procedures are restricted principally

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Id.

to the mentally ill.²⁵³

Substantive Due Process

Courts have now held that under substantive due process the mentally retarded have a right to treatment.²⁵⁴ The court in Wyatt v. Stickney forged a two pronged theory based on the Fourteenth Amendment: 1) the parens patriae concept and 2) the quid pro quo concept. Under the parens patriae concept the State has sovereign power over its disabled citizens including the mentally retarded to act as a parent in making

²⁵³ ORS Chapt. 427 provides that after a petition for commitment is filed by any person, the mentally retarded appear before a judge who may order a pre-commitment examination followed by another hearing and commitment if he is mentally deficient and in need of care, custody or training, ORS 427.015 et seq. He is informed of his right to an attorney, but nothing need be done to secure one for him. ORS 427.062. The statutes governing involuntary commitment of the mentally ill contain many more procedural requirements than do those concerning the mentally retarded. Kirkpatrick, L.C., Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel, Oregon Law Review, 1974, 53, 245. Senate Bill 79 was introduced in the 1977 Oregon Legislature in an attempt to provide more procedural safeguards for the mentally retarded. There are no procedural safeguards for "voluntary admission" of the mentally retarded or minors. While the proposed senate bill has no procedural safeguards for voluntary admission of minors, such legislation may be proposed regardless of the final decision in Bartley. Unfortunately this bill did not get out of committee for action on the legislative floor.

²⁵⁴ Wyatt v. Stickney, supra; Welsh v. Likens, supra.

decisions for them which they are unable to make for themselves. Consequently the State may deprive the mentally retarded of his liberty by confining him in a mental health facility or, as discussed earlier, may require appointment of a guardian or conservator or declare the person incompetent. Under the quid pro quo concept when the state takes away the mentally retarded's liberty, it must offer something in return. The "something" is treatment, reasonably designed to alleviate the need for continued loss of liberty.²⁵⁵ Based on this two pronged theory the court in Wyatt held that substantive due process under the Fourteenth Amendment requires that a mentally retarded person committed to a state mental health facility must receive treatment. The court reasoned: 1) civil commitment curtails individual liberty; 2) loss of liberty is predicated on a need for treatment; 3) the mentally retarded will be released when he is able to care for himself; 4) due process requires that he be given a reasonable chance to be cured.²⁵⁶

²⁵⁵ Wyatt v. Stickney, supra. See Martella v. Kelly, 359 F.Supp. (S.D. N.Y. 1973) (Effective treatment must be the quid pro quo for society's right to exercise control over civilly committed children.)

²⁵⁶ Comment: Wyatt v. Stickney and the right of Civilly Committed Mental Patients to Adequate Treatment, Harvard Law Review, 1973, 86, 1282.

In Wyatt a group of Alabama employees in a state mental health facility brought a class action challenging a state decision to terminate their employment because of budgetary cutbacks. The guardians of the mentally ill at the facility and finally the guardians of the mentally retarded at other facilities joined the class action as plaintiffs. They challenged the treatment, or lack of it, which the mentally disabled were receiving at state mental health facilities. District Court Judge Johnson heard testimony from many mental health professionals and from hospital and staff members. He ultimately concluded that under the Fourteenth Amendment the mentally deficient were entitled to adequate treatment. The defendant administrators of the state facilities in Alabama and Governor George Wallace appealed to the Fifth Circuit. However the Court of Appeals affirmed the district judge's decision and held that civilly committed mental patients have a constitutional right to receive such individual treatment as will help each of them to be cured or improve his or her mental condition. The court also affirmed the district court order that the defendants implement an elaborate set of standards of treatment, establish human rights committees at the institutions and prepare and file reports within six months concerning the implementation of the standards of treatment ordered by the court.²⁵⁷

²⁵⁷ Wyatt v. Aderholt, supra.

Equal Protection

Equal protection requires that all persons be treated alike under similar circumstances both in privileges conferred and liability imposed.²⁵⁸ Courts must scrutinize classifications of citizens to assure that the classifications are reasonable where fundamental rights are affected. The government must show a substantial and compelling reason for the classification.²⁵⁹

The equal protection clause of the Fourteenth Amendment by itself and in conjunction with the due process clause has been used as a basis for treatment.²⁶⁰ In Nason the

²⁵⁸ 16 Am.Jur. 2d, Constitutional Law § 488.

²⁵⁹ Halpern, *supra*, p. 393. See also Chambers, Alternatives to Civil Commitment of the Mentally Ill--Practical Guides and Constitutional Imperatives, Michigan Law Review, 1972, 70, 1107.

²⁶⁰ Nason v. Superintendent of Bridgewater State Hospital, 233 N.E. 2d 908 (Mass. 1968) (Nason, charged with murder, was found incompetent to stand trial and was committed to the Bridgewater Hospital in Massachusetts. On petition for release he urged that the hospital was understaffed and that treatment was so inferior to other hospitals in the state that his confinement there denied him equal protection of the law. The Massachusetts Supreme Court held that Nason's confinement did not satisfy the promise of treatment and the lack of treatment created substantial risk of violating the equal protection clause. If adequate efforts were not made to improve Nason's condition within a reasonable period, the legality of Nason's further confinement was questionable.)

Supreme Court of Massachusetts held:

If...treatment is not available on a reasonable, nondiscriminatory basis, there is a substantial risk that constitutional requirements of equal protection of the laws will not be satisfied. Differences in treatment may be justified by differences in particular cases, but should be reasonably related to the varying circumstances. 261

Reliance upon the equal protection clause has been criticized in that instead of requiring all states in a given state to meet the standards of the best hospital, it only requires equality among all. This penalizes those states which have made some progress and leaves unchanged uniformly poor conditions in other states.²⁶² This criticism, however, ignores the possible broader spectrum of the court's ruling which would require that the mentally ill or mentally deficient receive the same quality of treatment as persons suffering from physical ailments or the same as mentally deficient persons in private facilities.²⁶³

261

Id.

262

Goodman, S.M., Right to Treatment: The Responsibility of the Courts, The Georgetown Law Journal, 1969, 57, 680, 690-691.

263

Murdock, C.W., Civil Rights of the Mentally Retarded: Some Critical Issues, Notre Dame Lawyer, 1972, 48, 133, 160.

Eighth Amendment

Another constitutional basis for treatment is the prohibition of the Eighth Amendment against cruel and unusual punishment:

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.²⁶⁴

Courts have traditionally restricted its application to criminal defendants. In Wyatt, however, the court held that since confinement of a mentally ill or mentally retarded person deprives him of liberty until he is "cured", failure to provide necessary treatment so that the person be released constitutes cruel and unusual punishment. Application of the Eighth Amendment was used to require treatment in a recent California case, People v. Feagley.²⁶⁵ In Feagley the defendant was convicted of simple battery as the result of stroking the hair and necks of two young girls. The crime was a misdemeanor punishable by 30 days of imprisonment. However because Feagley had engaged in similar activities in the past he was also convicted for violation of California's sexual offender statute. As a consequence he was sentenced to a special colony for sexual offenders at

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U.S. Const. amend. VIII.

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14 Cal.3d 338, 121 Cal.Rptr. 509, 535 P.2d 373 (1975).

the state penitentiary. He received no psychiatric treatment and sought release under a writ of habeas corpus.²⁶⁶ The California court held that Feagley's incarceration without adequate treatment constituted cruel and unusual punishment in violation of the Eighth Amendment.²⁶⁷ Feagley was a convicted prisoner, but the Wyatt court recognized that the mentally disabled, including the mentally retarded, are in effect punished for being mentally ill or retarded and given indefinite sentences until "cured". Failure to provide treatment so that the "sentence" may be ended and liberty restored is cruel and unusual punishment.

²⁶⁶ Writ of habeas corpus--called the great writ, means literally "let us have the body". It is frequently used by prisoners and civilly committed mentally ill and mentally retarded to obtain release from confinement on the grounds that they are being wrongfully held.

²⁶⁷ People v. Feagley, supra. Comment: The Eighth Amendment Right to Treatment for Involuntarily Committed Mental Patients, Iowa Law Review, 1976, 61, 1057. In its ruling in Feagley, the court relied in part on Robinson v. California, 370 U.S. 660 (1962) (Defendant was arrested after police officers observed needle marks on his arm and was convicted of drug addiction. The court held that drug addiction is a status as is mental illness. The imposition of punishment for a status violates the Eighth Amendment.) But see Powell v. Texas, 392 U.S. 514 (1968) (Defendant was arrested for public intoxication and his conviction was affirmed, despite the fact he was an alcoholic, on the grounds that he could have avoided the criminal act by drinking at home. Therefore he was convicted for the prohibited act of drunkenness and not his status of being an alcoholic.)

Thirteenth Amendment

Another constitutional basis for treatment, although somewhat limited, is the Thirteenth Amendment.

Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States...²⁶⁸

Although the immediate aim of the amendment was the abolition of slavery, the amendment has been construed by the courts to require maintenance of a free and voluntary labor force.²⁶⁹

A recent case held that if a mentally retarded person can prove 1) that he was required to perform work involuntarily because of his mental condition and 2) the chores had no therapeutic purpose, but were performed solely to assist in defraying institutional costs, he may establish violation of the Thirteenth Amendment.²⁷⁰ The defendants argued that all involuntary civil commitment serves a compelling state interest in protecting society from the mentally retarded so that the question of whether or not the work was therapeutic was irrelevant. Their argument was rejected.

²⁶⁸U.S. Const. amend. XIII.

²⁶⁹Pollack v. Williams, 322 U.S. 4 (1944).

²⁷⁰Weidenfeller v. Kidulis, 380 F.Supp. 445 (E.D. Wis. 1974).

While the decision in Weidenfeller does not hold that the Thirteenth Amendment specifically requires treatment for the mentally retarded, it does establish that the mentally retarded must not be compelled to perform work that is non-therapeutic. Limitations on what kinds of work activities patients of mental health facilities may be required to perform have been imposed in several decisions which have required minimum treatment.²⁷¹

Statutory Bases

A fourth basis for treatment is statutory, including 1) state statutes specifically requiring treatment for the institutionalized mentally retarded;²⁷² 2) the Federal Civil Rights Act;²⁷³ and 3) the Developmentally Disabled

²⁷¹ See Davis v. Watkins, 384 F.Supp. 1196, 1208-1209 (N.D. Oh. W.D., 1974) (Patients not required under any circumstances to perform "[r]epetitive, non-functional, degrading, and unnecessary tasks...such as buffing a waxed floor that has already been sufficiently buffed, polishing brass, or shining employee's shoes."

²⁷² 1964 Hospitalization of the Mentally Ill Act, D.C. Code §21-562 (Supp.V., 1966) See Rouse v. Cameron, 125 U.S. App. D.C. 366, 373 F.2d 451 (1966).

²⁷³ 42 USC §1981 (1871).

Assistance and Bill of Rights Act.²⁷⁴

Rouse v. Cameron, one of the earliest cases to deal with the right to adequate treatment, suggested that there might be a constitutional basis for treatment as discussed earlier. The court's finding for the plaintiff however was specifically based on a District of Columbia statute:

A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all medical and psychiatric care and treatment received...²⁷⁵

Rouse was charged with a misdemeanor and found not guilty by reason of insanity and committed. Punishment for the crime was one year. Rouse had been institutionalized for four years, and sought release under a writ of habeas corpus because he contended he was not receiving adequate treatment. The trial judge refused to consider the question of adequate treatment stating that he could decide whether his treatment was adequate. The lower court trial judge dismissed Rouse's request for release. The appellate court, in an opinion by Judge David Bazelon, reversed the lower court's action and remanded the case to the trial judge to hear expert testimony and determine whether or not Rouse's treatment was adequate.

²⁷⁴ 42USC §6001 (1975).

²⁷⁵ Rouse v. Cameron, supra; D.C. Code §21-562, supra.

As discussed earlier, Oregon statutes provide that a person found not guilty of a crime by reason of a mental disease or defect may be committed if he needs care, supervision or treatment,²⁷⁶ or in the case of the mentally retarded--care, custody or training.²⁷⁷ Unlike the Washington D.C. statute, treatment is not specified for the mentally retarded.²⁷⁸ However it appears implicit that the committed mentally retarded have a right to treatment since 1) they will not be released until "cured" or no longer in need of care, custody or training, and 2) courts have indicated that mere custodial care is insufficient. There are no Oregon cases on point, and unfortunately for the committed mentally retarded person seeking treatment, the Oregon statutes are not as explicit in requiring treatment as are those of the District of Columbia.

²⁷⁶ ORS 161.340.

²⁷⁷ ORS 427.015.

²⁷⁸ A mentally ill person in Oregon has a statutory right to have a written treatment plan. ORS 426.385(g). The mentally retarded lack such statutory protection.

A second statutory basis for treatment is the Federal Civil Rights Act of 1871, which provides:

Every person who under color of any statute...of any State...subjects, or causes to be subjected any citizen of the United States or other person within the jurisdiction, thereof, to the deprivation of any rights, privileges or immunities secured by the Constitution, shall be liable to the party injured...²⁷⁹

The statute is essentially a codification of the Fourteenth Amendment. It is important to the mentally retarded seeking treatment because it specifies that if the mentally retarded is denied treatment and can convince the court that he had a statutory right to treatment he may receive money damages. Plaintiff in Donaldson v. O'Connor²⁸⁰ sought money damages under the Civil Rights Act from two physicians at a mental health facility for their failure to either provide treatment or release him. Donaldson had been confined in a Florida State Hospital for the mentally ill against his will for nearly 15 years and had repeatedly demanded release claiming he was dangerous to no one and at any rate was receiving no treatment. At numerous times friends and once a halfway house agreed to provide Donaldson any care he might require, but he was not released and continued receiving only custodial care. At the trial the trial judge instructed the

²⁷⁹42USC §1983.

²⁸⁰See Annot. Right to Relief Under Federal Civil Rights Act of 1871 for Alleged Wrongful Commitment to or Confinement in Mental Hospital. American Law Reports Federal, 1973, 16, 440.

jury that O'Connor violated Donaldson's civil rights under the statute if Donaldson was confined against his will, was not dangerous to himself or others and was not receiving treatment. The jury awarded Donaldson money damages totalling \$48,500. O'Connor appealed to the Fifth Circuit of Appeals which affirmed the judgment and held that a person confined against his will in a state mental institution has a "constitutional right to receive such treatment as will give him a reasonable opportunity to be cured or improve his mental condition."²⁸¹

The U.S. Supreme Court essentially affirmed the judgment of the jury at the trial level²⁸² but vacated the broad sweeping opinion of the appellate court and simply held that a state cannot constitutionally confine a nondangerous person

281

393 F.2d 507, 520.

282

O'Connor argued that he was not liable for money damages because he was acting in good faith in reliance on state law. The trial judge instructed the jury that O'Connor would not be liable if he believed in good faith that Donaldson's continued confinement was proper. The Supreme Court remanded the case to the Court of Appeals to decide whether the instruction effectively informed the jury that O'Connor would only be liable under the civil rights act if he knew or should have known that the action he took within his sphere of official responsibilities, would violate Donaldson's constitutional rights or if he took action with the malicious intent of violating Donaldson's civil rights.

capable of living in freedom by himself or with the help of family and friends. Since the jury found that O'Connor knowingly confined Donaldson, its judgment was affirmed. The court sidestepped the issue, however, of whether there was a constitutional right to treatment.

Specifically, there is no reason now to decide whether mentally ill persons dangerous to themselves or others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment.²⁸³

As a result of the Donaldson case, there is no Supreme Court authority that there is a constitutional right to treatment, nor conversely is there Supreme Court authority that there is no constitutional right to treatment. Donaldson does stand for the proposition that the mentally retarded or mentally ill person who believes that his constitutional right to treatment is violated may raise the issue by seeking money damages under the Federal Civil Rights Act. As a result of the Supreme Court's ruling in Donaldson, cases such as Wyatt are still viable rules of law in the jurisdictions involved and may be persuasive authority in other jurisdictions such as Oregon for the proposition that there is a constitutional right to treatment, but the decisions would not be binding on Oregon courts as a ruling by the U.S. Supreme Court would have been.

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422 U.S. 563, 669.

Another statutory basis for treatment is the Developmentally Disabled Assistance and Bill of Rights Act.²⁸⁴

Essentially the Act provides that in order for a state to receive part of the 50 million dollars allocated to construction, remodeling or alteration of facilities for the developmentally disabled, the state must provide the federal government with satisfactory assurances that it has implemented a habilitation plan for each mentally disabled person, setting forth the objectives and manner of achievement as well as a provision for an annual review of each treatment plan. In addition the act requires that the Secretary of Health, Education and Welfare promulgate regulations setting forth the kinds of services needed by the developmentally disabled and standards as to the scope and quality of the services.²⁸⁵ Congress also made specific findings concerning the rights of persons with developmental disabilities:

1) persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities;

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42 USC §6001-6081.

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42 USC §6009. The regulations have been proposed but have not yet been adopted.

2) the treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive to the person's personal liberty.

While the United States may not bring an action to require state facilities to comply with the act, the act does not restrict the rights of the individual to bring an action on his own.²⁸⁶ In addition the act specifically requires that States seeking funds under the act develop and maintain an independent advocacy system to pursue legal, administrative and other appropriate remedies to insure protection of the rights of persons receiving treatment, services, or habilitation within the State. ²⁸⁷

It is impossible to predict the success of the act in securing habilitation for the mentally retarded. The act's success or failure will depend upon the regulations finally adopted and the parameters of the act as established by administrative hearings and legal actions brought by the advocacy system required under the act as well as actions brought by individual mentally retarded persons.

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U.S. v. Solomon, 419 F.Supp. 358 (D.Md. 1976).

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42 USC §6012.

Negligence and Breach of Contract

In addition to constitutional and statutory bases for treatment, a mentally retarded person may have a cause of action against the state, treating physician, psychologists, psychiatrists or the superintendent or director of the mental health facility for negligence in failing to provide adequate treatment. If successful he will be awarded money damages.²⁸⁸ In Bartlett v. New York²⁸⁹ plaintiff charged the state with negligence in failing to release him from a state mental health facility after he had been involuntarily committed 37 years earlier as having "simple or low level schizophrenia"

288

Schwitzgebel, R., *The Right to Effective Mental Treatment*, supra, 936. The author notes that if a patient enters a mental hospital and does not leave or if treated and untreated patients do equally well in the facility, it is obvious that the patient has not been receiving proper treatment. In medical malpractice cases, the courts use the doctrine of res ipsa loquitur (the thing speaks for itself) to create a presumption of negligence against the doctor in causing injury to the patient. The defendants who are in a better position to know must explain the reason for the treatment given. In cases brought by the mentally retarded for non-treatment, the mentally retarded person would only need to show that his condition has not improved despite his commitment to a mental health facility. It would then be incumbent upon the state or the treating physician or psychologist to show that the mentally retarded person had received adequate treatment but because of his condition, treatment was of no value or as a result of the treatment given satisfactory improvement had occurred.

289

No. 340/1976, N.Y. Supreme Court, App. Div. (May 28, 1976).

despite his frequent requests that he be released because he was receiving no treatment. The trial court dismissed the claim on the ground that the state hospital was exercising professional judgment. Because it was making discretionary choices concerning the type, if any, of the treatment to provide the plaintiff it could not be liable.²⁹⁰

However on appeal the appellate court reversed:

The wrong committed by refusing such release is not the result of the exercise of a professional judgment, but of total indifference and neglect to duty. Such conduct removes the protection of governmental immunity.²⁹¹

The appellate court remanded the case to the trial court to determine the amount of the patient's damages based upon the length of time he was ready, willing and able to be released without danger to the community. The court did not specify what kind of treatment the patient was entitled to receive but only that he was entitled to treatment:

[A]lthough there may not be complete unanimity of opinion as to what treatment to extend to the patient; there can be no doubt that if the patient is detained because of mental illness, some treatment must be offered him.²⁹²

²⁹⁰ Originally the State and its employees could not be sued because of governmental or sovereign immunity. Most states including Oregon and the federal government have now passed tort claims acts which permit the government and its employees to be sued. However the State and its employees are not liable for discretionary decisions involving matters of policy nor for matters of professional judgment. ORS 30.150.

²⁹¹ Bartlett v. New York, supra.

²⁹² Id.

While Bartlett involved a mentally ill patient, the court's ruling would be equally applicable to a mentally retarded patient. However a difficulty pointed up by the case is the fact that the state and its employees are not liable for negligently making or failing to make policy decisions or in negligently making professional judgments. Consequently it may be difficult for the mentally retarded person to recover from the state or its employees for his non-treatment. For example, in Baker v. Straumfjord,²⁹³ the Oregon Court of Appeals held that a state employed physician at the Oregon State University infirmiry was not liable for injuries sustained by a mentally disturbed patient who leaped from a third floor window of the university infirmiry. Plaintiff alleged that as a patient he had not been adequately restrained or supervised. The court held that the physician was immune from liability because his decision concerning the care of the patient was based on professional judgment with which the court would not interfere.

Based on Baker it is unlikely that an Oregon court would hold the state or one of its employees liable in damages for negligently failing to provide a patient with

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10 Or.App. 414, 500 P.2d 496 (1972).

adequate treatment, unless the court were to have a case before it like Bartlett in which a total indifference and neglect to duty is shown. Until the court alters its application of the discretionary function defense to professional judgment or until the Oregon Tort Claims Act is amended by the legislature, liability for negligence is possible but not probable as a basis for treatment in Oregon.

It has also been suggested that a patient at a mental health facility might be entitled to recover damages when he has not received adequate treatment, under a breach of contract theory.²⁹⁴ This theory has been used sparingly in practice because there is usually no oral or written agreement between the psychologist and the patient. The benefits of having a contract have been outlined by Alexander and Szasz:

[I]t seems likely that while more precise definitions of the psychiatrist's contractual powers and limitations would curtail some of current psychiatric practices, it would expand others, by removing the presently justified fears of many persons to sacrifice their autonomy and yield to the total discretion of the psychiatrist.²⁹⁵

294

Schwitzgebel, R., *The Right to Effective Mental Treatment*, *supra*, 951.

295

Alexander & Szasz, T., *From Contract to Status via Psychiatry*, *Santa Clara Law Review*, 1973, 13, 537, 555.

The use of contracts for treatment would clearly define the expectations of the patient and the obligations of the psychologists or psychiatrist. The use of contracts has been effective in a mental health clinic in Florida²⁹⁶ and at the Elahan Clinic in Vancouver, Washington.²⁹⁷ The contracts specify treatment to be given and goals to be accomplished, encouraging patient participation. They do not however provide for money damages.

Several difficulties restrict implementation of contracts as a basis for treatment. First, despite the support advocated by professionals in the mental health field such as Thomas Szasz, it is questionable whether a psychologist or psychiatrist would want to enter into a contract which would limit his flexibility in treating the person or in agreeing in advance of treatment to specific results. Secondly, the patient after agreeing to treatment might subsequently refuse further treatment as he has a right to do.²⁹⁸ This

296

Lombilla, Kiresak & Sherman, Evaluating a Community Mental Health Program: Contract Fulfillment Analysis, Hospital and Community Psychiatry, 1973, 24, 760.

297

Casey, W., Director of Elahan (lecture, Portland State University, Feb., 1977).

298

Friedman, P.R. Legal Regulations of Applied Behavior Analysis, Mental Institutions and Prisons, Arizona Law Review, 1975, 17, 40.

would amount to a breach of contract by the mentally retarded person, but the psychologist or psychiatrist might not receive payment for any treatment already provided.

A major difficulty with the contract basis for treatment is that mentally retarded persons may be considered incompetent to enter into a contract. Under the common law they are deemed incompetent persons and are protected from contracting for services to restore their condition.²⁹⁹ In Oregon a person must have sufficient mental capacity to understand the nature of the business he is engaging in or he will not be able to enter into a contract.³⁰⁰ There would be nothing however, to prevent a psychiatrist, psychologist, or mental health facility from entering into a contract with the patient's family, guardian or friends for treatment and thereby provide a clear basis for determining the specific rights of both the patient and the psychologist or psychiatrist.

299

Schwitzgebel, R., *The Right to Effective Mental Treatment*, surpa, 953.

300

Gindhart v. Skourtes, supra. Limitations on the mentally retarded person's right to enter into contracts is discussed in Chapter III.

JUSTICIABILITY OF "ADEQUATE" TREATMENT CONTROVERSY

Opponents to judicial requirements that treatment be offered to the mentally disabled have argued that the provision of treatment is not a justiciable controversy.³⁰¹ Merely because there is a legal basis for treatment does not mean that a court will intervene by examining whether or not appropriate treatment has been given. The controversy must be appropriate for judicial scrutiny or a court will not review it.³⁰² In deciding whether or not the controversy is justiciable the courts consider three basic issues: 1) whether judicially discoverable and manageable standards exist for determining the rights of the parties; 2) whether a judicial determination will amount to an interference with

301

Burnham v. Dept. of Public Health, 349 F.Supp. 1335 (N.D. Ga. 1972), reversed, 503 F.2d 1319 (5th Circ. 1974) (Trial court held that it could not and should not become involved in the right to treatment issue. The court held that the judiciary was unable to determine what was adequate treatment because the definitions of psychiatric treatment were too broad. The judge was also of the opinion that there was no constitutionally recognized right to treatment. Finally, he determined that any attempt to ascertain the adequacy of treatment is best left to the state courts. The judge's decision was reversed on appeal to the Fifth Circuit Court of Appeals which held that there was a constitutional right to treatment and the adequacy was appropriate for review in the courts whether state or federal.

302

Shuster v. Herold, 410 F.2d 1071 (2nd Circ. 1969).

decisions by other branches of government; and 3) whether the courts can provide adequate relief.³⁰³

The defendants in Wyatt suggested that since even experts in mental health could not agree on minimum standards, the best approach would be for courts to defer to the judgment of involved professionals. They also argued that the establishment of policing of individual treatment plans should not be undertaken by a court and that a court could not choose among the vast array of psychotherapies. As they observed, the proper therapy or habilitation plan for one patient might be contraindicated by another. Defendant Governor George Wallace of Alabama also argued that 1) the court's action would require allocations of funds and other fiscal decisions which were the province of the Alabama Legislature and not the courts and 2) the real purpose of mental health facilities was to relieve friends and family of their custodial duties in attempting to care for the mentally deficient, and accordingly custodial care was all that was required.³⁰⁴

303

Comment: Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment, Harvard Law Review, 1973, 86, 1282, 1296.

304

Wyatt v. Aderholt, supra.

The court in Wyatt held, however, that the controversy was proper for the courts. A judge is not required to choose one treatment over another, and the court will simply review the treatment offered to assure that a number of habilitation alternatives are available. Treatment is required by the U.S. Constitution and not mere custodial care, so, having undertaken to provide facilities for the mentally deficient and permitting their involuntary commitment to these facilities, the state must allocate sufficient funds to provide adequate habilitation.³⁰⁵

SUMMARY

There are several legal bases for treatment or habilitation of the mentally retarded--constitutional, statutory and common law tort and contract theories. No single theory has become dominant, and further litigation can be expected. There is, however, a legal right to treatment which has been recognized by many courts, and those courts have determined

³⁰⁵ Offer, C.W., Field Report, Psychology Today, 1974, 61. (The author reviews Wyatt and notes that for some attorneys Wyatt and suits of its type are a stop gap measure with the ultimate goal closure of the institutions. Those attorneys and mental health professionals believe that adequate treatment within a large institution is by definition impossible. As a result many are proposing utilization of community based facilities.)

that the issue of whether or not treatment is adequate is appropriate for judicial review. Perhaps even more significant than judicial opinions is legislation, especially the Developmentally Disabled Assistance and Bill of Rights Act. Section 113 of the act requires that each state receiving formula grants for developmental disabilities' services must have an independent system for the protection and advocacy of the rights of persons receiving such aid by October 1, 1977. Implementation of these systems of advocacy may do much to secure the mentally retarded's right to treatment.

It has been suggested that the most effective method of providing treatment is through legislation rather than litigation.³⁰⁵ Legislation is not subject to the whims of individual judges and is not controlled by the particular facts before the court. This kind of limitation is well illustrated by the U.S. Supreme Court's decision in Donaldson³⁰⁶ in which the court restricted its holding to the rights of an individual who was not dangerous to himself and others and who had friends and relatives willing to provide for his care simply because that was the posture of the case before the court and it made its holding as restrictive as possible.

³⁰⁵ Rehabilitation Research and Training Center in Mental Retardation, Monograph 94, Eugene, Oregon: University of Oregon, 1976.

³⁰⁶ Donaldson v. O'Connor, supra.

It may be argued that since courts have recognized that there is a right to treatment and that the courts are competent and constitutionally authorized to evaluate the treatment given, it is now incumbent upon legislators to enact legislation providing for the right to treatment with some specificity. Additionally, almost all of the cases have concerned mentally retarded patients in state facilities. This has occurred because many of the legal bases discussed earlier require some type of state action. Legislatures need not be so restricted and may enact legislation securing treatment for noninstitutionalized mentally retarded persons who have or may suffer a deprivation of liberty.

Whether these rights are secured by judicial opinion or legislation there is a need for an interdisciplinary approach with psychologists providing appropriate guidelines.

CHAPTER V

CONCLUSION

Psychologists have generally accepted the normalization principle and the court in Wyatt v. Stickney has issued orders in an attempt to implement it in an institutional setting. There is no judicial opinion of national impact, such as a decision by the U.S. Supreme Court, accepting the normalization principle. In fact, the Supreme Court refused to hold either that the mentally retarded do have a constitutional right to treatment or that they do not. This chapter will examine the present legal provisions for treatment and the countervailing pressures in the push toward deinstitutionalization and least restrictive alternative. The prospect of legislation as a more feasible approach for securing effective treatment for the mentally retarded is discussed and recommendations are made.

LEGAL PROVISIONS IN OREGON

By statute Oregon has established state hospitals for

treatment of the mentally ill,³⁰⁷ and for the "care and training" of the mentally deficient.³⁰⁸ The statutes relating to the mentally ill do not specify the kind of treatment to be provided but only that the person may be discharged when he is no longer mentally ill.³⁰⁹ The mentally ill person who has been committed does have a right 1) to have a written treatment plan, 2) to be kept current with his progress, and 3) to have some protection from the use of potentially unusual or hazardous procedures and mechanical restraints as discussed in Chapter IV.³¹⁰ These rights are not insured by statute for the retarded. The mentally retarded person whether involuntarily committed or voluntarily admitted will only be discharged when he is no longer a "fit subject for institutionalization".³¹¹ The statute is unclear, as is the legislative history of the kind and quality of treatment to be provided, if any, to the patients. An

³⁰⁷ ORS 426.010.

³⁰⁸ ORS 427.010.

³⁰⁹ ORS 426.300.

³¹⁰ ORS 426.385.

³¹¹ ORS 427.250.

indication of the kind of treatment the legislature deems adequate may be found in the delineation of services which, by statute, are to be provided out-patients at the state facilities. These services include diagnostic services, advice and other "necessary" services.³¹² What constitutes necessary services is unclear. Arguments could be made that it is mere custodial care. A review of psychological literature, would indicate that necessary services means all tested methods of achieving normalization. Legislative amendment or judicial clarification are required.

Oregon statutes require special education for handicapped children in addition to regular classes--special classes, special schools, special services, home instruction or hospital instruction.³¹³ Handicapped children include mentally retarded children under age 21.³¹⁴

The standards for determining adequacy of instruction are not specified in the statutes. Oregon statutes provide for a State Advisory Council for Handicapped Children, composed of parents and educators of handicapped children, which advises the Superintendent of Public Instruction and the State Board of Education on the special education programs.³¹⁵

³¹² ORS 427.106.

³¹³ ORS 343.035(3), 221.

³¹⁴ ORS 343.035(2).

³¹⁵ ORS 343.287.

Administrative agency regulations promulgated by the Oregon Department of Education provide for hearing procedures to be followed prior to a child's placement in a different educational program. The hearing procedures require notice, and afford the parents the right to be represented by an attorney, and to present testimony at the hearing. There are also administrative regulations concerning the minimum education standards for state institutions serving the mentally retarded.³¹⁶

Oregon statutes and regulations provide for care, training and education but are far from outlining a plan for habilitation such as the following proscribed in Wyatt:

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs regardless of age, degree of retardation or handicapping condition.

2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.

* * *

- 3.c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents

from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community; (6) dependent to independent living.³¹⁷

DEINSTITUTIONALIZATION

As a result of decisions such as Wyatt and various articles by mental health professionals there is an increasing emphasis toward deinstitutionalization. Wyatt and cases like it have set high standards requiring individualized treatment, reasonable staff/patient ratios and certain minimal living conditions. The high cost and responsibility of maintaining the institutions has led many states to establish group homes in community settings. Also based upon the principle of normalization and deinstitutionalization mental health professionals have advocated use of group homes in the community.³¹⁸ Four problems may be seen as possible impediments

³¹⁷ Wyatt v. Stickney, supra, 396.

³¹⁸ Courts, which are given through statutes or judicial opinions alternatives to commitment, are often unaware of the alternative kinds of placement available. Mental health professionals must act as promoters for community care and assure that explorations for alternatives actually occur. It has also been suggested that courts employ a staff member to advise them of the various alternatives available. Alternative To Mental Hospital Treatment, Hospital and Community Psychiatry, 1976, 27(4), 186, 187. The Multnomah County Public Defender's Office has an alternative worker assigned to every attorney representing mentally ill or retarded clients.

in the move toward deinstitutionalization: 1) there is considerable pressure from lobbyists for labor unions and state employees to keep the institutions operating;³¹⁹ 2) the community may not welcome mentally retarded into the neighborhood to live in a group home and may enact zoning laws to restrict occupancy; 3) as discussed in Chapter I, the mentally retarded are a very diverse group and there may be more opportunity to work with and be instructed with other mentally retarded persons with comparable development and intelligence in a large institution rather than a smaller group home;³²⁰ and 4) funding affects what theory is implemented or legislation applied.

Construction of large mental health facilities can mean more jobs for workers. Group homes would also, but unions tend to favor construction on large projects,³²¹ and state employees are reluctant to lose jobs at the institutions.

319

In California where the state had begun to close institutions in favor of group homes, lobbyists forced the state to reverse itself and institutions are no longer being closed.

320

Tarjan, G., Wright, S.W., Eyman, R.K. & Kenan, C.V., Natural History of Mental Retardation: Some Aspects of Epidemiology, American Journal of Mental Deficiency. 1973, 77(4), 369, 373.

321

Blatt, B., The Executive, in Changing Patterns in Residential Services for the Mentally Retarded (Rev. ed.) Kugel, R.B. & Shearer, A. (ed.) Washington, D.C.: President's Committee on Mental Retardation., 1976.

As noted in Chapter IV, the action in Wyatt v. Stickney was originally begun by a group of disgruntled state employees. Interestingly, as a part of its judgment the court directed the employment of 300 additional state employed staff workers.³²² As a result, legislators and elected judges have even more constituents who may be seeking maintenance of the institution because of the jobs it affords.

The fact that a small residential care facility is moving into the community is in keeping with the theories of normalization and least restrictive alternative treatment, but may not be in keeping with what some of the residents believe is appropriate for their community. Traditionally urban communities have zoning ordinances which only permit one or possibly two family dwellings in a neighborhood and those families must be related.³²³ As a result local governments and some courts have compared a family care home for the mentally retarded to a boarding house and required that it be located in a commercial zone.³²⁴ Most zoning ordinances also allow for

322

Gilhoal, T.K., The Uses of Courts and of Lawyers, in Changing Patterns, supra.

323

Chandler, J.A. & Ross, S., Jr., Zoning Restrictions and the Right To Live in the Community, in The Mentally Retarded Citizen and the Law, supra.

324

Id.

variances from the comprehensive zoning plan or conditional use permits to permit construction or occupancy in an otherwise inappropriate zone if it is compatible with existing use. However because of the possibly harmful effect on land values, such variances are difficult to obtain.

It has been suggested that the zoning problem might be alleviated by requiring the owner to first obtain a license to operate a group home. The granting of the license might depend on such factors as a "planned treatment" program, adequate supervision, and a program to obtain community acceptance.³²⁵ This kind of legislation, or recognition that "family" may entail more than relatives, together with a program of community education and awareness could help alleviate this zoning problem.

The availability of funds determines the kind of program available. This paper has not presented any kind of economic cost analysis comparing the cost of operating a group home with a large institution.³²⁶ However, as discussed in Chapter 4, Governor Wallace in Wyatt v. Stickney argued that the State

325

Kressel, L., The Community Residence Movement: Land Use Conflicts and Planning Imperatives, New York University Review of Law and Social Change, 1975, V(2), 137.

326

See Boggs, E.M., Quality Control of Community Services, in Mentally Retarded Citizen and the Law, supra.

of Alabama could not afford the kind of treatment that the experts testified was required. The court in Wyatt held that the adequacy of funding was no excuse for failing to provide adequate treatment. Also the availability of federal funds under the Developmentally Disabled Assistance and Bill of Rights Act may be of considerable impact in this area as discussed in Chapter IV.

LEAST RESTRICTIVE ALTERNATIVES

Whether in large institutions or in group homes there is a growing consensus that the mentally retarded are entitled to habilitation in the least restrictive setting , however the consensus has thus far been restricted to the institutionalized mentally retarded. As pointed out in Chapter I, a large number of mentally retarded are not institutionalized; but, as discussed in Chapter III, their liberty has been restricted by such legal devices as guardianship. It has been suggested in the area of guardianship that under the least restrictive alternative a guardian should only be appointed for those specific things that the mentally retarded cannot do for himself.³²⁷

327

Gearheart & Litton, *supra*.

Perhaps the least restrictive alternative could be carried an additional step to require that the guardian receive assistance in planning the education and activities of his mentally retarded ward utilizing the principles of normalization. Neither the legislatures nor the courts have taken any strong action to expand the theories of normalization and least restrictive alternative to the non-institutionalized mentally retarded.

LITIGATION VS. LEGISLATION

Both the legislatures and the courts have been active in law for the mentally retarded, especially the institutionalized. As stated earlier, the 1960's era was one of legislation while the 1970's has been one of litigation. But litigation has recently been criticized for the following reasons: 1) it is expensive to hire the attorneys and expert witnesses and to conduct a thorough investigation; 2) a final determination by a judge could take two to three years; 3) the decision is usually restricted to the facts before the court and not a universal rule such as the legislature might enact; 4) the mentally retarded's opposition--usually the state--has appeared in litigated cases with more frequency and better financing, and thus might be better prepared; and 5) the court may be lacking resources and expertise to

carry out any treatment plan it might impose.³²⁸

Test case litigation has been a catalyst in generating heightened public concern for the mentally retarded, but it appears that we are now returning to an era of legislation. Legislatures can establish uniform standards, have more staff and finances to investigate without stifling appropriate experimentation, and can appropriate the funds to carry out legislation.³²⁹

It has been suggested that all three branches of government working together would be effective.³³⁰ The legislatures could establish strict guidelines for administrators and provide them with necessary finances. The administrators could run the institutions, and the courts

³²⁸Krawles, R., Litigation vs. Legislation in The Right to Treatment/Habilitation for Mentally Retarded Persons: A Review and Proposal, Rehabilitation, Research and Training Center in Mental Retardation, Eugene, Oregon, 1976; Gilhoal, T.K., The Uses of Courts and of Lawyers, in Kugel, R.B. & Shearer, A. (eds.) Changing Patterns in Residential Services for the Mentally Retarded (rev.ed.). Washington, D.C.: President's Committee on Mental Retardation, 1976. Gilhoal suggests that groups advocating the rights of the mentally retarded organize themselves into litigation groups so that they can become repetitive litigants as are insurance companies, prosecuting attorneys and collection agencies. This would give the mentally retarded more expertise in litigating and more opportunity to see that the court's orders were carried out.

³²⁹Krambs, *supra*.

³³⁰Johnson, R.H. & Wood, J.J., Sr., Judicial, Legislative, and Administrative Competence in Setting Institutional Standards, in The Mentally Retarded Citizen and the Law, *supra*.

could ensure that the legislative and administrative responsibilities have been satisfied.

All branches of government work cooperatively to protect the consumer. We are living in an age of consumerism and even the mentally retarded citizen can be seen as a consumer of services. The services are provided by the institutions³³¹ and by private mental health professionals as well. If the mentally retarded are seen as consumers they may be offered the appropriate protection afforded consumers. As Discussed in Chapters III and IV, the mentally retarded person may be able to contract for services with the institution and with mental health professionals. Utilization of a contract not only generates expectancy but also may give the mentally retarded a cause of action against the institution or the private person when the services are not provided.

The law and psychology are beginning to approach their mutual concerns for the mentally retarded with some sense of cooperation and unity of purpose. Current concepts and applications discussed in Chapter II have implications for minimum treatment guidelines formulated by legislatures

³³¹Wyatt v. Stickney, supra. Dr. Phillis Roos, Executive Director for the National Association for Retarded Children in his testimony repeatedly referred to the mentally retarded as the consumers of the services offered. See also Schwitzgebel, R.K., The Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria, Harvard Civil Rights-Civil Liberties Law Review, 1973, 8, 513.

or by the courts. For example, the fact that behavior modification can assist the mentally retarded person achieve normalization illustrates a need for more staffing in order to achieve one to one patient/staff ratios necessary in some behavioral therapy. However, in utilizing behavioral therapy care must be taken that the treatment is performed legally and ethically. As discussed in Chapter III, Oregon patients have some rights concerning use of unusual or possibly harmful procedures as a part of their treatment process. Consequently these legal restrictions on what may be done to treat the mentally retarded must be considered.³³² In addition to legal constraints on utilizing certain forms of treatment there are certain ethical constraints such as informed consent of the treatment to be given. The consent should be based on an understanding of the procedure, totally voluntary and given by a competent person.³³³

332

There is growing literature on what has been described as the right to avoid treatment. It is primarily concerned with shock treatments, physical deprivation, and forms of punishment as therapies for altering behavior. This paper does not address this issue. The interested reader should see Symposium: Behavior Control, Arizona Law Review, 1975, 25, 1.

333

Guidelines for the Use of Behavior Procedures in M.R. Research. Arlington, Texas: National Association for Retarded Citizens, 1976.

RECOMMENDATIONS

In light of the conclusions reached, the following are suggested activities for assisting the mentally retarded achieve habilitation:

1) More emphasis on research of the retarded in the community, on community living versus institutionalization, and on special education versus integrated, mainstreamed classes.

2) Development of national standards incorporating ideological principles of normalization, a developmental approach to services, consumer participation and protection of the mentally retarded person's legal and human rights. As discussed in Chapter I, organizations such as the National Association for Retarded Children and the American Association on Mental Deficiency have devised various standards throughout their existence and may be able to do so in this case. Additionally, Judge Johnson in Wyatt adopted specific minimal treatment standards for the mentally retarded which have been widely followed.

3) Re-evaluation and amendment of present laws dealing with the retarded concerning personal and community rights as outlined in Chapter III. For instance, elimination of special laws on contract, marriage, sterilization or adoption -- in keeping with the principle of normalization could be effected.

4) Adoption of legislation giving the mentally retarded a statutory right to adequate treatment in light of current knowledge to meet his or her needs; provision in the statute for creation of a committee to develop and revise minimum standards and to preside over a patient's challenges to the treatment given; establishment of a treatment monitoring team which will periodically review each patient's treatment plan to evaluate adequacy; and establishment of a manual which sets forth required minimum treatment levels.

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OAR 581-15-025

OAR 581-15-110