



10-1-1972

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Recommended Citation

Charles W. Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame L. Rev. 133 (1972).

Available at: <http://scholarship.law.nd.edu/ndlr/vol48/iss1/7>

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CIVIL RIGHTS OF THE MENTALLY RETARDED: SOME CRITICAL ISSUES

Charles W. Murdock*

I. Introduction

From the surge of recent litigation it appears that the civil rights movement has at last discovered another oppressed minority¹—those persons encompassed within the rather unhappy label of “mentally retarded.”² The purpose of this article is to focus upon three areas affecting the civil rights of the mentally retarded: guardianship, institutionalization, and education. These areas were chosen because they are both critical and topical.³ They also raise a rather disquieting question about our traditional notion, solidly engrained in the law, that the parent is the proper advocate for the child.

Before investigating the aforementioned areas, I would like to engage in a brief critique of the title of this article. By so doing, I may be able to provide a better perspective for the reader. The title contains two troublesome phrases: “civil rights” and “mentally retarded.” There is no question but that the term

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1 The size of this minority group is surprisingly large:

It is estimated that there are 6.1 million people in the United States (3% of the population) who should be identified as mentally retarded before they are 15 years old. Between 100,000 to 200,000 of the babies born each year are likely to join this group. By 1980, natural population growth is expected to increase the total to 6.8 million, unless far-reaching preventive measures can be introduced.

Of the total about 2.4 million are children and youth under 21 years of age. At least 2.1 million of these children are mildly retarded and many of them may not be singled out and identified until they have been in school for several years. Another 144,000 or more are estimated to fall in the moderately retarded category, with an additional 120,000 in the severe and profound categories.

NATIONAL ASSOCIATION FOR RETARDED CHILDREN, *FACTS ON MENTAL RETARDATION* 5 (1971) [hereinafter cited as *FACTS ON MENTAL RETARDATION*]. See also Haggerty, Kane, & Udall, *An Essay on the Legal Rights of the Mentally Retarded*, 6 *FAM. L. Q.* 59, 62 (1972).

2 I have used the adjective “unhappy” in connection with the label “mentally retarded” not only because, for most people, the condition of being mentally retarded is considered an unhappy one but also because of the problems in defining what is meant by mental retardation. “In the light of the history of controversy about the nature of intelligence, its organization, its predictability, and its susceptibility to change, it is not surprising that no single definition of subnormality has ever been satisfactory to all concerned.” H. ROBINSON & N. ROBINSON, *THE MENTALLY RETARDED CHILD—A PSYCHOLOGICAL APPROACH* 27 (1965) [hereinafter cited as ROBINSON]. The American Association on Mental Deficiency has promulgated the following definition: “Mental Retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.” *Id.* at 33-34. Not only is there a problem in defining mental retardation, but there is a further problem in distinguishing among the various levels of retardation. See note 6 *infra*. See also BAUMEISTER, *MENTAL RETARDATION—APPRAISAL, EDUCATION AND REHABILITATION* 1-19 (1967). This book is an informative collection of original papers by specialists in psychology, medicine, special education, and speech and hearing therapy.

3 As to the critical nature of these areas, see text accompanying notes 11, 42, and 126, *infra*. As to the topical aspect of retardation, particularly the aforementioned three areas, note that since the first of this year, *TIME* magazine has twice focused upon retardation in its section on medicine. *TIME*, Feb. 14, 1972, at 68-69; *id.*, May 8, 1972, at 51-56. See also *U.S. News & WORLD REPORT*, Sept. 18, 1972, at 58-62; *New York Times*, Oct. 9, 1971, at col. 4; *id.*, Mar. 26, 1972, at 35, col. 2, and *BEHAVIOR TODAY*, Mar. 20, 1972, at 1: “Flood of litigation to change status quo in mental hospitals and schools for retarded amounts to across-the-board campaign for civil rights of mentally handicapped.”

"civil rights" is now an "in" term to the professionals in the mental retardation field and the litigators in the current court cases who have adopted the term just as enthusiastically as the leaders of the black community did some two decades ago.⁴ However, it could be argued that there is a substantial difference between the two situations. The black was simply asking for what the white man then enjoyed. On the other hand, the retardate, because of his disability, may appear to the outsider to be making an extraordinary demand upon government rather than asking for that which is generally available to a person as an ordinary incident of citizenship. Thus, the question arises as to whether the concept of civil rights⁵ is sufficiently broad to cover the rights for which the advocates of the retarded are contending. This question will be analyzed further in the balance of this article.

Equally troublesome—if not more so—is the use of the term "mentally retarded," since such use connotes the impression that we are talking about a homogeneous group, which is simply not the case.⁶ That the retarded are,

⁴ See, e.g., BEHAVIOR TODAY, note 3 *supra*.

⁵ As Justice Warren has stated in his Civil Rights Lectures reprinted herein:

The rights protected by the Bill of Rights are old and honored ones which have come down to us as the product of Anglo-Saxon civilization in which we have our roots. Freedom of religion, of expression, of association, participation in government, the privacy of the home, freedom from self-incrimination, and the right to civilized procedures before, during and after civil and criminal trials, are basic to our way of life, and with other guaranteed rights are called either civil rights or civil liberties.

Warren, *Notre Dame Law School Civil Rights Lectures*, 48 NOTRE DAME LAWYER 14 (1972).

However, the term "civil rights" also includes, for example, those arising under the equal protection clause of the fourteenth amendment which requires states to treat their citizens equally. When states instead act in a discriminatory fashion, the retarded have a sound claim that their civil rights have been abridged. See text accompanying and following note 100 *infra*.

⁶ Within the general concept of retardation there are subdivisions reflecting the degree of impairment:

Degrees of mental retardation are measured by considering both "measured intelligence" and "impairment in adaptive behavior." For descriptive convenience the range of mental retardation has been divided into four levels—mild, moderate, severe, and profound. Children who are classified as mildly retarded (frequently called "educable mentally retarded" by educators), although limited in their potentials for advanced academic achievement, can usually be brought by special educational techniques to a state of self-sufficiency as adults. Moderately retarded children show a rate of mental development which is less than half of that normally expected, but can nevertheless 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, but their potential economic productivity is limited.

The profoundly retarded also respond to training in basic self-care, and they additionally profit from special training in such areas as behavior control, self-protection, language development, and physical mobility.

FACTS ON MENTAL RETARDATION, *supra* note 1, at 4.

In order to place these categories in better perspective, the following table from BAUMEISTER, *supra* note 2, at 10, may be helpful:

Word description of retardation in measured intelligence	Corresponding IQ range for	
	Stanford-Binet SD-16	Wechsler SD-15
borderline	68-83	70-84
mild	52-67	55-69
moderate	36-51	40-54
severe	20-35	25-39
profound	below 20	below 25

contrariwise, a rather heterogeneous group can best be demonstrated by the following examples.

Consider first the situation of a mildly retarded ghetto child from a minority group (particularly a minority group with a language barrier, such as the Chicanos or Puerto Ricans), who is living at home and whose retardation may be environmental rather than biological, as compared to a non-ambulatory, biologically profoundly retarded child who is institutionalized. This contrast is as sharp as the difference between night and day. In the case of the ghetto child, his prospects for living a "normalized" life are quite good; in fact, his advocates may be contending that he is not retarded at all, but rather that the testing procedures which have so labeled him are deficient.⁷ In the case of the

The following table, which appears in *FACTS ON MENTAL RETARDATION*, *supra* note 1, at 15, may give some idea as to the dispersion of the various degrees of retardation and the incidence thereof in the general population:

ESTIMATES OF RETARDATION BY AGE AND DEGREE—1970

1970 Census	All Ages	Under 21 Yrs.	21 Yrs. and above
General Population	203.2 million	80.5 million	122.7 million
3% General Population	6.1 million	2.4 million	3.7 million
Retarded			
Profound (IQ 0-20)	92 thousand	36 thousand	56 thousand
About 1½%			
Severe (IQ 20-35)	214 thousand	84 thousand	130 thousand
About 3½%			
Moderate (IQ 36-52)	366 thousand	144 thousand	222 thousand
About 6%			
Mild (IQ 53+)	5.4 million +	2.1 million +	3.3 million +
About 89%			

The term "educable" is often used coextensively with the term "mildly retarded" and the term "trainable" is often used coextensively with the term "moderately retarded." If nothing else, the controversy over definitions has developed terminology more palatable than that which formerly existed. "For many years, the terms *idiot*, *imbecile*, and *moron* were used in United States to denote abilities roughly in the I.Q. ranges 0 to 30, 30 to 50, and 50 to 70, respectively." ROBINSON, *supra* note 2, at 49. See also IND. STAT. ANN. § 8-101(c)(2) (1964), where an incompetent is defined as a person who is incapable by reason of "... imbecility [or] idiocy . . . of either managing his property or caring for himself or both."

Also, illustrative of the "loose" language used in some statutes to denote mentally retarded patients are the following statutes:

The purpose of this institution shall be to care for, support, train and instruct feeble-minded children, the term feeble-minded to include idiotic, epileptic and paralytic children.

Trustees shall make special provisions that low-grade inmates shall not associate with the better more improved grades, and epileptics shall be kept separate from all other grades as much as possible.

Id. §§ 22-1703, 22-1725.

⁷ A class action suit was filed in the United States District Court for the Northern District of California, *Larry P. v. Riles*, Civil No. C-71-2270 (N.D. Cal., filed Nov. 22, 1971), in which six black elementary aged children who have been placed in special education classes for the mentally retarded contend that they are "the victims of a testing procedure which fails to recognize their unfamiliarity with the white middle class cultural background and which ignores the learning experiences which they may have had in their homes." The defendants include state and local school officials and board members. See also Ross, DeYoung & Cohen, *Confrontation: Special Education Placement and the Law*, 38 EXCEPTIONAL CHILDREN 5 (Sept. 1971); South Bend Tribune, Apr. 24, 1972, at 24, col. 7 (where it was reported that the board of directors of the local ACTION, Inc. had adopted a resolution embodying recommendations "seeking an end to the branding of culturally deprived children as 'mental retardates'").

institutionalized child, however, his mode of living in many instances would defy characterization as human.⁸ Obviously the rights for which each child contends will differ markedly.

As a second example, consider the situation in a state in which the "educable"⁹ retarded are in the public schools, the "trainable"—depending upon the extent to which the county in which they reside avails itself of a local tax levy for a mental retardation center¹⁰—have poor or adequate programs, and the "severely and profoundly" retarded have little or nothing in the way of programs. Here, the retarded as a group have little in common; the educable may be quite content with their situation, whereas the severely and profoundly retarded have nothing to lose by challenging the *status quo*. It may well be that if litigation were to ensue, the retarded simply would not present a unified front.

II. Guardianship

The problem of guardianship will be examined first because it illustrates the potential conflict of interest which may exist between parent and retarded child—and such conflict may vitiate the "consent" or "voluntariness" which is a relevant and perhaps a critical factor when dealing with the area of institutionalization.¹¹

In analyzing the guardianship topic the following question must be considered: Should the law presume that the parent has both the motivation and the capability to represent the best interests of the retardee whenever matters affecting his welfare come in question or is there the need to develop some special

8 See text and footnotes commencing at note 45 *infra*.

9 See note 6 *supra* for a discussion of the degrees of retardation.

10 See, e.g., IND. STAT. ANN. §§ 22-3015, 22-3014 (1964) which provide:

22-3015. As used in this act the terms "community mental health center" and "community mental retardation center" shall mean a program of services approved by the department of mental health and organized for the purpose of providing multiple services for the mentally disordered and operated by one of the following or combinations thereof.

1. Any city, town, county or other political subdivision of this state; any agency of the state of Indiana or of the United States; and any political subdivision of another state; including but not limited to and without limiting the generality of the foregoing, hospitals owned or operated by units of government and building authorities organized for the purpose of constructing facilities to be leased to units of government;

2. A corporation incorporated under the provisions of the "Indiana General Not for Profit Corporation Act";

3. A nonprofit corporation incorporated in another state; and

4. A university or college.

22-3014. The board of county commissioners for a county may authorize the furnishing of financial assistance to any community mental health center or any community mental retardation center located, or which may hereafter be located, in the county for the purpose of constructing and/or operating the center. The county council of the county, upon request of the board of county commissioners, may appropriate annually, from the general fund of the county, funds to provide financial assistance for construction and/or operation of the center in an amount of not to exceed the amount which could be collected from the annual levy up to a ten cent (10 cent) tax on each one hundred dollars (\$100) of taxable property within the county.

11 See text following note 78 *infra*.

form of advocacy to insure that the rights of the retarded are adequately safeguarded and implemented?¹²

Our natural reticence in facing such a suggestion stems from the fact that deeply rooted in our legal¹³ and sociological¹⁴ heritage is the position that parents are the natural guardians of their children. Implicit in such a position is the belief that there is an identity or, at least, compatibility of interest between the parent and the child as well as a capability on the part of the parent to care for and deal with the child and represent him in his dealings with society's institutions. However, the time may have come to challenge this fundamental assumption.

12 As is stated in THE PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, MR 70—THE DECISIVE DECADE 22 (1970) [hereinafter cited as THE DECISIVE DECADE]:

The President's Committee is working to develop model guardianship provisions that will encourage the retarded individual to exercise all the citizen rights that he is capable of exercising, give him the benefit of equal protection under the law with all other citizens, and promote the development in states of public advocates for the retarded (and other handicapped) who will serve both as counselors and as surrogates as necessary.

The above titled book is the 1970 annual report of The President's Committee on Mental Retardation. Each year the Committee prepares and publishes such a report. The nature of the President's Committee on Mental Retardation is explained in FACTS ON MENTAL RETARDATION, *supra* note 1, at 15, where it is stated:

The President's Committee on Mental Retardation was appointed in May, 1966. The Secretary of Health, Education, and Welfare is chairman; members are the Secretary of Labor, the Director of the Office of Economic Opportunity and 21 distinguished men and women.

The Committee evaluates Federal mental retardation programs; coordinates the activities of Federal agencies in the mental retardation fields; provides liaison between Federal activities and related activities of state and local governments, foundations, and other private organizations; disseminates information to the general public to reduce the incidence of mental retardation and ameliorate its effects.

For more information write directly to The President's Committee on Mental Retardation, Washington, D.C. 20201.

13 As an illustration of the legal position with respect to guardianship, IND. STAT. ANN. § 8-105 (1964) is representative in its approach. This section provides:

Except as otherwise determined in a divorce proceeding or in some other proceeding authorized by law, the father and the mother jointly, if living and competent, or the survivor shall be the natural guardians of their minor children unless such child is married.

See also H. CLARK, LAW OF DOMESTIC RELATIONS § 8.4, at 245 (1968); KATZ, WHEN PARENTS FAIL—THE LAW'S RESPONSE TO FAMILY BREAKDOWN (1971); Caruso v. Superior Court, 2 Ariz. App. 134, 406 P.2d 852 (1965), *rev'd*, 100 Ariz. 167, 412 P.2d 463 (1966).

14 The sociological position is well stated in W. Wolfensberger & H. Zauha, Citizen Advocacy and Protective Services 1 (unpublished manuscript in the Notre Dame Law School Library):

In their relationship with each other or their children, spouses can be said to exercise both "instrumental" and "expressive" functions (Parsons & Bales, 1955). Instrumental functions are those which solve the practical problems of everyday life, such as earning a living, mowing the lawn, washing the dishes, and bathing the children. Expressive functions involve the exchange of affection that meet deep-seated needs and that often make instrumental demands meaningful or bearable.

Generally, in our society a child has one or two parents who provide for his physical and emotional needs, who socialize him into the larger culture, and who vigorously represent his interests. As time passes and as the child grows up, the parental role becomes less instrumental, but it retains its expressive nature for life. In other words, as long as parents live, they remain a source of emotional ties and support to their children, even though the parental functions become less and less problem-solving and task-oriented.

The expressive function of parenthood implies a deep emotional commitment. Ordinarily, this commitment to the person of the child lasts through life and persists even when the parent disapproves of the young (or grown) child's behavior. Indeed, this commitment is usually firmer and more stable than that of marriage; it can scarcely be called a rational one—but then, society does not expect it to be. To the contrary, most people would agree that it is desirable that every person have at

The fact that our guardianship laws presently in operation are not effectively dealing with the needs of the retarded has been pointed out by the President's Committee on Mental Retardation:

Most states' provisions for guardianship of the retarded are relics of a time when the mentally retarded individual was considered an incompetent who had to be kept away from normal social and work contacts. They largely consider or assume the retarded person to be without rights, deny him due process or the equal protection of the laws, and often encumber his family's estate for years as the price of the state's assuming his care. The damage done to retarded individuals who are capable of self-support and self-reliance, to those who have become caught up in the judicial process, and to families who can be in effect held responsible for a retarded individual into a second generation is incalculable.¹⁵

Professor Richard Allen, Director of the Institute of Law, Psychiatry and Criminology at George Washington University, has also chronicled deficiencies in our present guardianship laws.¹⁶ However, the concern raised in this article transcends

least one relationship that endures beyond rationality, and that it is not terminated by erratic or unsanctioned behavior or by misfortunes that may befall a human life.

Our society highly endorses, but does not legally demand, expressive parental role performance. In contrast, instrumental parental role performance is, to a significant degree, mandated by law. Thus, while parental failure to demonstrate or extend love to a child is not punishable by law, parents are made legally responsible for their children's support, and child neglect or abuse is punishable.

The aforesaid manuscript is to be published by The President's Committee on Mental Retardation. Doctor Wolfensberger is currently a visiting scholar with the National Institute on Mental Retardation, York University Campus, Toronto, Ontario, Canada.

15 THE DECISIVE DECADE, *supra* note 12, at 22.

16 In R. ALLEN, LEGAL RIGHTS OF THE DISABLED AND DISADVANTAGED 23 (1969) the author has stated:

Some of the shortcomings of typical state statutes and procedures are the following:

1. The terminology is imprecise; and as has been pointed out earlier, because of inappropriate use of terms, a determination in one area may create the status of general "incompetency";

2. Guardianship proceedings are cumbersome and expensive;

3. Both the terminology employed and the procedures required create unnecessary stigma for the retarded person in need of help and unnecessary pain for parents seeking to insure that he will get it;

4. Institutionalization often creates at least a *de facto* if not a *de jure* incompetency;

5. Most courts do not have facilities for clinical evaluation, nor do they have sufficient staff to oversee the discharge of fiduciary responsibility by guardians or institutional personnel;

6. Often the alleged incompetent is not really represented by counsel, even when the procedure requires appointment of an attorney *ad litem*; and the determination is frequently made *ex parte*;

7. There is great uncertainty as to when a guardian of the person should be appointed, and what his duties should be;

8. There is no established procedure for review of the competency of an institutionalized person upon his reaching his majority;

9. Guardians of the person are rarely appointed for those in residential care institutions;

10. Guardianship is an "all or nothing" situation although in many cases partial or limited guardianship is all that is required;

11. Few States have established a system under which a state agency can assume some or all of the functions of a guardian when there is no one else who can fill this role;

12. In part because of lack of community resources, and in part because of misconstructions of existing law and regulations, in some States it is necessary to go through a commitment proceeding to receive needed protective services.

many of the problems which the foregoing authorities raise in that it questions whether, in many situations, the *parent* adequately represents the interests of his retarded child.¹⁷ Such inability may result from either a conflict of interest between parent and child or from the disparity in sophistication between the parent and the agency which is acting hostilely to the child.

A. *The Conflict of Interest Problem*

The conflict of interest facet of the guardianship problem is well illustrated in the decision as to whether or not to institutionalize a retarded child. The nature of this conflict has been stated in the amici brief in *Wyatt v. Stickney*:¹⁸

The parent may be motivated to ask for such institutionalization for a variety of reasons other than the best interests of the child himself, *i.e.*, the interests of other children in the family, mental and physical frustration, economic stress, hostility toward the child stemming from the added pressures of caring for him, and perceived stigma of mental retardation. The retarded child's best interests may well lie in living with his family and in the community, but theirs may not lie in keeping him.¹⁹

17 This comment certainly is not meant to be a blanket criticism of parents of retarded children. It was the refusal of parents to accept the indictment of professionals and society that their children were hopeless that spurred many of the positive developments in the field of mental retardation, including the organization of the National Association for Retarded Children.

However, as the following text illustrates, there are many situations in which the parent does not adequately represent the interest of the child. It thus becomes necessary to sort out and identify those situations and to provide the parents with an effective advocate for the child.

The role that parents *qua* advocates have filled has been recognized internationally:

There are many other examples from the international scene showing parent associations as effective change agents. In the United States, the National Association for Retarded Children (NARC), with its research fund and distinguished research advisory board, contributed substantially to a change in scientists' view of this field as a legitimate and worthwhile area for scientific inquiry. From Canada, the Ontario Association for Retarded Children mobilized international interests in the special physical training needs of mentally retarded children and adolescents. In Western Australia, it was the parent associations which introduced a specialized clinic for the study of the mentally retarded in a setting since taken over by the state. In England, the National Society for the Mentally Handicapped contributed substantially to a change in service concepts for the severely retarded by the establishment of a national training center and hostel at Slough and of vacation and short-stay homes. Finally, in a symposium held in Stockholm in 1967, the International League of Societies for the Mentally Handicapped developed new formulations of the individual rights of the mentally retarded which have been recognized widely as the forerunner of a whole new conceptualization in the field of mental retardation, underpinning the broader concept of normalization.

CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED 399-400 (B. Kugel & W. Wolfensberger, eds. 1969) [hereinafter cited as *Changing Patterns*].

18 325 F. Supp. 781 (M.D. Ala.), *formulation of minimum standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *implementation of standards ordered*, Civil No. 3195-N (M.D. Ala., Apr. 13, 1972). For a discussion of the first stage of this protracted and complex litigation see Drake, *Enforcing the Right to Treatment: Wyatt v. Stickney*, 10 AM. CRIM. L. REV. 587 (1972); Briefs for American Psychological Association, American Orthopsychiatric Association, American Civil Liberties Union, and American Association on Mental Deficiency as Amicus Curiae, *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) [hereinafter cited as *Wyatt v. Stickney*, Amici Briefs]. These briefs were authored by Stanley Herr, NLADA National Law Office, Washington, D.C.; Charles R. Halpern, Center for Law and Social Policy, Washington, D.C.; Bruce Ennis, American Civil Liberties Union, New York; and James F. Fitzpatrick, Jeffrey D. Bauman, and Stephen M. Sacks, Arnold & Porter, Washington, D.C.

19 *Wyatt v. Stickney* Amici Briefs, *supra* note 18, at 34-35.

Moreover, there are many societal pressures operating to induce parents to institutionalize a retarded child ranging from uninformed medical opinion to the parents' own "success" oriented expectations of their children.²⁰ It would certainly appear appropriate where institutionalization is in the offing to provide the retarded child with his own advocate as a countervailing force to insure that the alternatives to institutionalization are explored.²¹

Probably the most graphic illustration of the dichotomy of interest between parent and child is found in the well publicized occurrences²² in which minor corrective surgery has been withheld from mongoloid infants born with intestinal obstructions. In one such instance the child was set aside in the corner of the hospital nursery with a sign on the crib, "nothing by mouth."²³ The result, of course, was a slow, agonizing death from dehydration.²⁴

20 There are physicians who refer families to these residential facilities but who have never seen the facilities and do not know the professional personnel caring for the clients whom they refer. This is an odd paradox since one cannot imagine a physician referring a patient to a hospital for an operation if he knew nothing about the place and people involved.

CHANGING PATTERNS, *supra* note 17, at 2-3. Another author has commented:

Comparing the results with those of earlier studies, we concluded that there is a growing trend favoring home care of every young child whenever possible. However, many—including most of the obstetricians interviewed (who have perhaps least contact with retarded children, but whose opinion may weigh most heavily with parents at that traumatic time of first discovery of an apparent impairment)—still urge institutionalization of retarded children under 6, even in the face of parental objection (especially in the case of the mongoloid child, whom they view with despairing negativism). In fact, a majority of obstetricians said they would recommend institutionalization of *all* infants recognized as retarded where there are other children in the home. Only 17 percent of the pediatricians and psychiatrists and none of the institutional physicians would agree.

R. ALLAN, *supra* note 16, at 13-14. In Shaw, *Doctor, Do We Have a Choice?*, The New York Times Magazine, Jan. 30, 1972, at 44, the author has stated:

I know many physicians with Mongoloid children. Almost all have placed them in institutions. Couples who are success-oriented and have high expectations for their children are likely to institutionalize their mentally deficient offspring rather than keep them at home. The argument that Mongoloids raised in the home perform better than those raised in an institution is rarely persuasive with such parents.

21 Recent studies have indicated that the presence of a retarded child in the home need not have a disruptive effect:

It is heartening to see changes in professional attitudes toward putting retarded children into institutions. Until recently, such placement was almost universally advised; all too frequently the advice was based on the belief that a handicapped person always "contaminated" the family and generated great psychological burdens. Our findings that the reactions of other family members are not inevitably determined by the nature and degree of the handicap itself cut through this mistaken belief. It is the family's definition of the problem that most directly affects the ability of individual members of the family to adjust to a retarded child. The presence of a retarded child can enhance a family's normal development, or at least not hinder it. The recent shift away from institutions is only partly due to this realization. Other influences are the rising costs of placement, increased awareness of the harshness of the institutions, and growing sensitivity to the negative effects that placement and separation have on the whole family.

Grossman, *Brothers and Sisters of Retarded Children*, *PSYCHOLOGY TODAY*, April, 1972, at 82, 104; see also B. FARBER, *MENTAL RETARDATION: ITS SOCIAL CONTEXT AND SOCIAL CONSEQUENCES* (1968) (particularly ch. 7).

22 See, e.g., Shaw, *Doctor, Do We Have a Choice?*, *supra* note 20; see also note 23 *infra*.

23 This situation was depicted in the film, *Who Should Survive*, filmed at Johns Hopkins Hospital and produced by the Joseph P. Kennedy, Jr. Foundation for the International Symposium on Human Rights in Washington, D.C.

24 Assuming *arguendo* that parents do have the right to forego surgery for the child (as the following text will establish, they do not), the question may be asked why the physician cannot take some affirmative action, such as injecting an air bubble into the child's vein, to foreshorten the inevitable suffering. The law has always drawn an active/passive dichotomy

It is hard to conceive of a conflict of interest more fundamental than that just described because what is at stake is the life of the child.²⁵ If society—rather than labeling this failure to provide the child with ordinary care what it is, namely, infanticide—condones this approach, a logical extension of the operative attitudes would permit any parent of a retarded infant not to feed it, with the same attendant ultimate consequences. This is so because the efficient cause of not feeding the infant with the intestinal obstruction is not that the child would vomit upon feeding—since the cause of the vomiting was readily correctible—but rather the desire of the parents not to be burdened with a retarded child.²⁶

Most individuals would question the practical likelihood of the aforemen-

with respect to this subject. See WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 318-326 (1957). However, the present topic illustrates that the sophistry involved in drawing such a distinction produces a totally inhumane result. If the child is to die because it is retarded, better it die quietly than in agony.

25 One may wonder whether the life of a retarded child is of such dignity that the deprivation thereof can properly be described as infanticide. One author, in discussing the tremendous cost to society which the care of the retarded entails, has stated: "While I do not for one moment wish to place a price tag on a human life, I cannot help wondering how the same sum spent on normal children might advance the interests of society." Neal, *Some Genetic Aspects of Therapeutic Abortion*, *PERSPECTIVES IN BIOLOGY AND MEDICINE* 133, 134 (Autumn 1967). Dr. Stanley Hauerwas of Notre Dame, in an essay prepared for the Kennedy Foundation, characterizes Dr. Neal's position as a ". . . charity run wild and gone crazy because it is unable to totally relieve the world of its suffering . . . This charity no longer has the patience to attempt to act justly in a world wracked with suffering." S. Hauerwas, *The Christian Society, and the Weak: A Meditation on the Care of the Retarded* 8 (to be published in 1 N.D. Magazine Oct. 1972). Dr. Hauerwas puts the moral significance of caring for the retarded in this perspective:

The retarded are the sign that all men have significance beyond what they can be for us—our friend, our playmate, our brother; each of us is precious and significant because his being is grounded in God's care. The retarded, the poor, the sick, are but particularly intense forms of God's call to every man through the other. Thus, God calls us to regard each other as significant as we each exist for Him, as we are each God's gift to the other.

Id.

In essence, the real question being raised here is whether, at least in part, the "problem" of retardation can be resolved by eliminating the retarded. Abortion in many jurisdictions is already a legally acceptable procedure for dealing with the problem. See MODEL PENAL CODE § 207.11(2)(a) (1961) (abortion justified if there is substantial risk of mental defect); Annot., 28 L.Ed. 2d 1053 (1972) (validity of abortion laws from a constitutional standpoint). With the advent of amniocentesis, abortion as a solution to the problems of retardation will probably increase significantly. See Milunsky, *Prenatal Genetic Diagnosis* (pt. 3), *THE NEW ENGLAND J. MEDICINE*, Dec. 31, 1970, at 1498, 1501-03. One author has suggested that bringing a child into the world who might later experience extreme physical or emotional pain as a result of known defects should be avoided at any costs. Lappe, *The Genetic Counselor: Responsible to Whom*, *HAST. CENTER REP.* No. 2, at 6-7 (Sept. 1971). Daniel Callahan has replied to this argument, in part:

. . . I find it hard to see how the goal of the moral life can be reduced to the mere "reduction in the operation of evil," i.e., suffering, without undergoing a great deal of impoverishment in the process. The search for truth, for instance, requires a positive (and sometimes painful) effort; and justice is a positive state of affairs, not just the absence of suffering. The point of the moral life, I take it, lies in trying to decide what we should seek and then seeking it, not just in finding out how to avoid suffering.

Id. at 11. As the legal and ethical framework for dealing with the situation of the retarded develops, it will be interesting to note whether justice or expediency becomes the touchstone.

26 One author, in discussing the decision of the parents of a mongoloid child not to have an operation performed, has stated:

The choice they made was—no surgery. They had no intention of raising a human being whose maximum achievement might be the ability to write his own name. Furthermore, they did not wish to sentence their child to an institutional existence. "If I knew the baby would be a Mongoloid," Mrs. G. said, "I would have had an abortion."

Shaw, *Doctor, Do We Have a Choice?*, *supra* note 20, at 44, 52.

tioned extension, that is, not feeding an otherwise normal retarded child. It is inconceivable that a well-balanced set of parents would determine not to feed a retarded infant. How then can assumedly equally well-balanced parents decline surgery and permit their child to die of dehydration? While superficially the distinction lies in a medical rationale—the decision whether or not to operate—the real distinction lies in the fact of an institutionalized setting in one instance and a home environment in the other. In other words, as will be further developed in this article,²⁷ the greatest danger to the mentally retarded child lies in the institutional setting—in this case because it affords the parents the opportunity to “distance” themselves from the child and deal with the situation in an abstract manner, namely, in the doctor’s office instead of at home where the cries of the child are a constant call to the normal parental instincts and an impetus to reconsider the decision not to operate.²⁸ If the hospital, after the decision not to operate is made, told the parents to take the child home, would there not, in many instances, be an immediate reconsideration of the decision not to operate?

Notwithstanding the foregoing possibility of an administrative type resolution, how should the law operate upon this traumatic conflict of interest? In seeking a legal resolution, there appears to be a close parallel between the mongoloid child’s situation and the Jehovah’s Witnesses cases in which courts have ordered blood transfusions over parental objection predicated upon religious beliefs.²⁹ Jurisdiction of the court may be based upon either the so-called “neglected child” statutes³⁰ or, relying on the doctrine of *parens patriae*, the general equity powers.³¹ A liberal interpretation of the so-called “child abuse”

27 See text following note 42 *infra*.

28 As one of the doctors who has been involved in this dilemma has stated:

As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff—much more so than for the parents who never set foot in the nursery.

Shaw, *Doctor, Do We Have a Choice?*, *supra* note 20, at 53.

29 *E.g.*, *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962), *cert. denied*, 371 U.S. 890 (1962); *Annot.*, 30 A.L.R.2d 1138 (1953). See also *Glozman v. Cosgrove* 49 N.J. 22, 227 A.2d 689, 693 (1967), where the court rejected a cause of action against a doctor for failing to apprise the parents during pregnancy of the substantial risk of a defective child in order that they might procure an abortion. The court adhered to the position that the unborn child’s right to life was of greater importance than the interest of the parents in being free from emotional and financial injury:

It is basic to the human condition to seek life and hold onto it however heavily burdened. If Jeffrey could have been asked as to whether his life should be snuffed out before his full term of gestation could run its course, our felt intuition of human nature tells us he would almost surely choose life with defects as against no life at all. “For the living there is hope, but for the dead there is none.” Theocritus.

30 See generally CLARK, *supra* note 13, § 17.3 at 581-82; *id.* § 18.5 at 629-36; KATZ, *supra* note 13. For an example of specific statutory provisions see IND. STAT. ANN. §§ 9-3201 *et seq.* (1956) (particularly § 9-3206, where a neglected child is defined in part as one who is “in an environment dangerous to life, limb, or injurious to the health or morals of himself or others”); *id.* §§ 52-504, 52-505 (1964) (which authorizes a court to transfer custody of a neglected child to the public welfare department). See Young, *The Problem of Neglect—The Legal Aspects*, 4 J. FAM. L. 29 (1964).

31 The power to protect children and act for their welfare was acknowledged to be part of equity jurisdiction in England at least as far back as the Seventeenth Century, although the origin of the jurisdiction remains in dispute. It is usually explained as being derived from the Crown’s prerogative as *parens patriae* to protect those of

statutes³² might even impose upon the hospital the duty to notify the appropriate authorities so that legal action may be commenced. With this line of precedent, it can hardly be said that "nothing can be done" if the parents do not act, a plaint uttered by some medical personnel.

B. *Inability to Deal Effectively with Institutional Society*

The other facet of parental inability to represent adequately the best interests of the retarded child lies in the inability of many well-intentioned parents to deal effectively with the public and private institutional providers of service. For example, the parent of a child in a special education class within the public school system is likely to hesitate to question the quality of the program since the threat of exclusion weighs heavily in the parents' minds. The parent is realistically aware that the cost of a private program is prohibitive and that the public program is better than that which the parent could provide at home. Similarly, a parent of a child who has been voluntarily admitted to a state institution would hesitate to challenge the quality of the care provided because the child is constantly subject to the threat of subtle—and not so subtle—retaliation.³³ Addition-

the Crown's subjects who are unable to protect themselves . . . The jurisdiction has likewise been recognized from the earliest times in the United States, and it's now largely covered by local statutes.

CLARK, *supra* note 13, at § 17.1.

32 A typical statute provides as follows:

The declared purpose of this act . . . is to provide for the protection of children who have had physical injury inflicted upon them and who are further threatened by the conduct of those responsible for their care and protection. Physicians, interns, residents, laboratory technicians, nurses, pharmacists, chiropractors or other persons furnishing medical aid becoming aware of such cases should report them to the County Department of Public Welfare or the law enforcement agency having jurisdiction thereby invoking the protective services of the state in an effort to protect the health and welfare of these children and to prevent further abuses.

Acts of 1965, ch. 268, § 1, Ind. Laws (repealed 1971) language incorporated Ind. Ann. Stat. § 52-1427 (Burns Cum. Supp. 1972). See also Annot., 12 A.L.R.2d 1047 (1950).

33 One opportunity for the use of the not so subtle form of retaliation is what is euphemistically referred to as "therapeutic isolation." Therapeutic isolation operates in the following fashion:

Many dormitories for the severely and moderately retarded ambulatory residents have solitary confinement cells or, what is officially referred to and is jokingly called by many attendants, "therapeutic isolation." "Therapeutic isolation" means solitary confinement—in its most punitive and inhumane form. These cells are usually located on an upper floor, off to the side and away from the casual or official visitor's scrutiny. . . . Isolation cells are generally tiny rooms, approximately 7 feet by 7 feet, shielded from the outside with a very heavy metal door having either a fine strong screen or metal bars for observation of the "prisoner." Some cells have mattresses, others blankets, still others bare floors. None that I had seen (and I found these cells in each institution visited) had either a bed, a wash stand, or a toilet. What I did find in one cell was a 13- or 14-year-old boy, nude, in a corner of a starkly bare room lying on his own urine and feces. The boy had been in solitary confinement for several days for committing an institutional infraction, as I recall, directing abusive language to an attendant. Another child, in another institution, had been in solitary confinement for approximately 5 days for breaking windows. Another had been in isolation, through a long holiday weekend, because he had struck an attendant. Ironically, in the dormitory where this boy was being incarcerated, I saw another young man who had been "sent to bed early" because he had *bitten off* the ear of a patient several hours previously. Apparently, it is infinitely more serious to strike an attendant (and it should not be misunderstood that I condone this) than to bite off the ear of another resident.

CHANGING PATTERNS, *supra* note 20, at 41-42.

ally, the parent may feel that if he disturbs the *status quo*, the child may be thrust back upon him. Moreover, the parent is likely to be unaware of the professional standards which the institution must meet and the political and quasi-political pressures which can be brought to bear upon the institution. Finally, he probably does not have the financial resources to effectively challenge the institution, either in a legal forum or otherwise.³⁴

How then may the question as to the need for a new form of advocacy for the retarded be answered? First, except in extraordinary situations, there is no need to oust the parent as guardian of the child. However, there is a critical need for the development of supplementary and complementary advocacy models—both from a legal advocacy³⁵ and a lay or citizen advocacy standpoint.³⁶ Furthermore, whenever institutionalization is involved—and here “institutionalization” should be broadly defined so as to encompass within its ambit both the situation

34 The sheer extent, size, and monetary value and the economic utility to certain communities, of the current physical plants, facilities, and services for the mentally retarded tend to block or delay action toward change. On the one hand, the objecting vested interests are very strong, and on the other, changes, in order to be effective, have to be of a radical, almost revolutionary rather than evolutionary, nature. *Id.* at 391-92.

35 Legal advocacy models are already developing. The favorable results in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala.), *formulation of minimum standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *implementation of standards ordered*, Civil No. 3195-N (M.D. Ala., Apr. 13, 1972), are in large part attributable to the consortium of amici, composed of public interest law firms and public spirited lawyers who entered the litigation, together with the civil rights attorneys from the Justice Department which has recently established a new division to deal with institutions. The amici have now taken steps to form a National Council on the Rights of the Mentally Impaired, to continue litigation to protect the mentally impaired, particularly those involuntarily confined to public institutions. Notre Dame Law School, in conjunction with the National Association for Retarded Children, The Council for The Retarded of St. Joseph County, and the American Bar Association, has formed a National Center for Law and the Handicapped, one whose missions will be to provide advocacy services for the mentally retarded. See also Kay, *Legal Planning for the Mentally Retarded: The California Experience*, 60 CALIF. L. REV. 438 (1972).

36 The need and importance of community volunteers is described as follows:

A vital factor on the American social scene is the volunteer, and in this particular context, the volunteer who as an interested citizen activist gives freely of his time to participate vigorously in organizing, guiding, and critically reviewing and appraising human welfare services in his community, his state, and his country. As an independent citizen without vested interests in the subject matter, he is often an ideal person to call to public attention disturbing developments which require change, such as the existence of dehumanizing, unworthy, or inadequate services to other human beings. To the degree that it requires controversy to accomplish this, he can and should create such controversy. To the degree that sustained publicity is required to elicit public concurrence, he is in a position to develop it. In the role of ombudsman, adopted from the Scandinavian model, he can introduce a new pattern of safeguarding the rights of the mentally retarded, of their parents, and also of those who work with the retarded. Citizen volunteers can perform an invaluable service by gaining the support of individuals or groups in the community who for various reasons are opposed to the initiation and maintenance of services and facilities on behalf of the mentally retarded. Without the help of volunteers, change may be long delayed; with their active participation, change may be considerably accelerated.

It is of vital importance that there be always consumer groups and citizen activists who retain their freedom to criticize the established agencies and policies. Thus, such consumers and activities should be careful not to be maneuvered into situations of financial or other dependency upon the agencies they should survey. However, agencies such as institutions, state departments concerned with institutions, and other service systems could increase their orientation to change by employing some intelligent, alert consumers as well as attorneys as staff members in order to actively seek out ways of safeguarding the rights and welfare of the clients, investigate complaints, and communicate with citizen and consumer groups.

If, in this fashion, citizen volunteers, consumer groups, professional organizations,

of the hospitalized mongoloid infant with the intestinal obstruction and the placement of a retarded child within special education classes of the public school system—it would appear desirable, if not absolutely necessary, to provide the services of a concerned, yet uninvolved (in the sense of personally intimidated by the situation) third party,³⁷ whether it be a guardian *ad litem* (*ad institutionalem*) approach or the citizen advocacy approach espoused by Dr. Wolf Wolfensberger.³⁸

and government collaborate as equal partners on the local, state, and national level, they will constitute a powerful force for change and for accomplishing a vital social task.

CHANGING PATTERNS, *supra*, note 20, at 401.

With respect to the concept of ombudsman see Cheng, *The Ombudsman or Citizens Defender: A Modern Institution*, *THE ANNALS*, May, 1968, at 20; note 38 *infra*.

37 It almost goes without saying that the advocate for the retarded should not be the institution in which he is confined or anyone subject to its influence. An obvious conflict of interest exists. Yet, many statutes provide that, for example, the superintendent of an institution in which the individual is confined may be appointed as guardian of the ward's estate. *E.g.*, *IND. STAT. ANN.* § 22-1256 (1964). While the foregoing statute relates only to the estate of the ward, this is not because it is contemplated that someone else will be appointed as guardian of the person, but rather no guardian of the person is contemplated. In other words, our guardianship laws are more concerned about the estate than the person of the incompetent. The burden caused by the conflict of interest which inheres in any institution, or an employee of such institution, when designated as guardian falls upon the client:

When a professional person provides protective services as part of his agency-defined duties, it is almost inevitable that he will experience conflicts of interest or of loyalty. By the very way in which our system works, the interests of the client must be expected occasionally to be at variance with the interests of the agency. This places the professional in the middle, and human nature and our system being what they are, professionals more commonly internalize the interests of the agency than of the client. In contrast to the agency which has many voices and much power, a retarded person's voice and power, for instance, are zero unless someone else speaks for him. Professionals whose career interests, reward systems, and social system ties lie within agencies—as is commonly the case—cannot be expected to provide impaired persons with the loud, loyal, consistent, unwavering voice they need.

Wolfensberger & Zauha, *supra* note 14 at 5.

38 The foremost "advocate" of citizen advocacy is Dr. Wolfensberger. He has defined citizen advocacy thus:

[A] mature, competent citizen volunteer representing, as if they were his own, the interests of another citizen who is impaired in his instrumental competency, or who has major expressive needs which are unmet and which are likely to remain unmet without special intervention.

Viewing the interests and welfare of the impaired person as if they were his own, the mission of the advocate is to use culturally appropriate means to fulfill the instrumental and expressive needs of such a person, consistent with cultural norms and with the person's impairments and potentials. For lack of a better term, and especially to avoid use of the term "ward," I shall refer to the impaired person in an advocacy relationship as a "protege."

In order to represent someone's interests as one's own, one must pursue a strategy which minimizes potential conflicts of interest. Thus, the advocacy concept demands that advocacy for an impaired person is to be exercised not by agencies, and not by professionals acting in professional roles, but by competent and suitable citizens. To underline these emphases, one can quote as an example from Article V of the Declaration of General and Specific Rights of the Mentally Retarded adopted in October of 1968 by the International League of Societies for the Mentally Handicapped: "No person rendering direct services to the mentally retarded should also serve as his guardian." (*ILSMH*, 1969).

Conceivably, advocates can function singly or in groups, and represent the interests of both individual persons as well as groups of persons. However, the heart of the proposed advocacy scheme is individual advocacy, in which one citizen is the advocate for one other citizen. It is primarily with this type of advocacy that this treatise will concern itself.

Wolfensberger & Zauha, *supra* note 14 at 6. Doctor Wolfensberger has been instrumental in adopting the Citizen Advocacy Approach in the State of Nebraska. These programs have been described in the August 1970 issues of *THE ROTARIAN* and the *READER'S DIGEST*.

The need for special advocacy is greatest in the institutional setting. Experience has demonstrated that the gravest threats to the welfare and even the life of the child exist in such a setting.³⁹ Also, because of the distancing⁴⁰ involved in such a setting, the parent can easily delude himself that "things really aren't that bad" and can absolve himself from further responsibility when the child is entrusted to the institution. Finally, because of the disparity in leverage and sophistication that normally exists between parent and institution, the parent, in many cases, is simply not capable of effectively dealing with the institution.⁴¹

III. Institutionalization

This, then, leads to the further question as to the rights to which an institutionalized retarded child is entitled. While there are many rights, including the right to visitation by family members at all reasonable hours,⁴² the right to be compensated for their labors,⁴³ and the right to normal relationships with the opposite sex,⁴⁴ for which advocates of the retarded might contend, probably the two most critical are the right to a humane physical and psychological environment and the right to adequate treatment. The question to be hereinafter con-

39 See text accompanying and following note 45 *infra*.

40 See text at note 28 *supra* for an illustration of distancing.

41 See text following note 32 *supra*. See also Cheng, *The Ombudsman or Citizens Defender: A Modern Institution*, *supra* note 36, at 30 for a discussion of the complexity of governmental administration and the attendant need for some sort of ombudsman scheme: "[F]aced with a huge and complex body of governmental instrumentalities, an aggrieved citizen may not even know where or to whom to complain."

42 Statutes often provide for a right of family visitation during all reasonable periods. Cf. Ind. Ann. Stat. § 22-1034 (1964). However, institutions often try to discourage family visitation, in large part because of the deplorable conditions, particularly in the so-called "back wards." See text and footnotes following note 45 *infra*. Visitation is also indirectly curtailed by locating a child in an institution which is at a great distance from the family home. A good critique of visitation procedures in the mental illness area is found in S. BRAKEL & R. ROCK, *THE MENTALLY DISABLED AND THE LAW* 158 (rev. ed. 1971).

43 *Townsend v. Treadway*, Comm'r, Tenn. Dep't of Mental Health, Civil No. 6500 (M.D. Tenn., filed Feb. 16, 1972) (alleging that the inhabitants of the institution were required to perform labor and services without adequate compensation, thereby giving rise to a constitutional cause of action predicated upon involuntary servitude); *but see* *Employees of Dep't of P.H. & W. v. Dep't of P.H. & W.*, 452 F.2d 820 (8th Cir. 1971), *cert. granted*, 405 U.S. 1016 (1972) (where the court held that, notwithstanding the Fair Labor Standards Act, employees of the state could not sue the state).

44 In effect, what the advocates of the retarded are moving toward is the adoption of what is known as the "normalization principle." This principle will be relevant in connection with the discussion of the "least restrictive alternative," see text accompanying note 61 *infra*, and in dealing with the high cost, both in terms of dollars and wasted life, in connection with institutional care. See text at note 110 *infra*. An excellent discussion of the normalization principle is found in CHANGING PATTERNS, *supra* note 20, at 179-196. The author defines the principle as follows:

Thus, as I see it, the 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 main stream 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.

Id. at 181. Effective implementation of this principle has already been accomplished in the Scandinavian countries.

sidered is whether such "rights" are legally cognizable. While it is proper for the advocates of the retarded to speak of rights, such semantics are not meaningful until the posited rights are secured by legislative or judicial recognition. Litigation, which may ultimately provide the answer, is presently in progress in several jurisdictions.

A. *Present Abuses*

Before examining the legal precedents and course of the present litigation, it would be wise to explore the factual situation giving rise to the need to seek judicial recognition of constitutional standards with respect to the care of the retarded in an institutional setting. Reference has already been made to the articles in the news media⁴⁵ referring to the "warehousing" of retardates in institutions. Comparable situations also have been substantiated by professional investigations.

In 1948, Albert Deutsch, in reporting upon the conditions at the Philadelphia State Hospital for Mental Diseases, stated:

. . . 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 living under leaking roofs, surrounded by moldy, decaying walls, and sprawling on rotting floors for want of seats or benches 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 payroll⁴⁶

Later, in 1965, Dr. Burton Blatt, Chairman of the Special Education Department of Boston University, and Fred Kaplan, a photographer, gained access to a number of institutions for the mentally retarded in order to produce a photographic essay on institutional conditions. Their study confirmed that the conditions described above continued to exist:

In each of the dormitories for severely retarded residents there is what is euphemistically called a day room or recreation 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. Most day rooms have a series of bleacher benches on which sit unclad residents jammed together without purposeful activity, communication, or any interaction. In each day room is an attendant or two, whose main function seems to be to "stand around" and, on occasion, hose down the floor "driving" excretions into a sewer conveniently located in the center of the room. . . .

. . . . The question one might ask is, Is it possible to prevent these conditions? Although we are convinced that to teach severely retarded adults to wear clothes one must invest time and patience, we believe it possible to do so—given adequate staff. There is one more requirement.

⁴⁵ See note 3 *supra*.

⁴⁶ DEUTSCH, *THE SHAME OF THE STATES* 42-43 (1948).

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 that 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.⁴⁷

More recently, in Massachusetts, the March, 1971, report of the Joint Special Commission on Belchertown State School and Monson State Hospital reported the following conditions:

At Belchertown the buildings are old, crowded, sparsely furnished and frequently cold. Repairs at times go unattended for months. On occasion, the fire alarm system has been inoperative

. . . . Doors to residential buildings often cannot be opened due to the age of the locking system.

At Belchertown there are continuing unnecessary shortages of sanitation supplies, such as disinfectant, detergents and mops, directly resulting in the daily spread of infection among the residents

. . . . Cockroaches have been chronic, ever present and in the recent past, have overrun several buildings to the extent of crawling over immobile patients

. . . . There is no semblance of privacy at Belchertown.

. . . . Punishment has bordered on cruel and abusive treatment.

. . . . Unnecessary and incorrect medication has been given to residents.

. . . . Prescribed medical care is delayed or ignored for long periods of time. There are frequent shortages of medical supplies and drugs. In many cases, recommended corrective orthopedic surgery, as well as the fitting of eye-glasses and hearing aids has been delayed for several years. These delays further reduced the resident's ability to function and in some cases delayed discharge from the institution for years.⁴⁸

Most recently, Dr. Philip Roos, Executive Director of the National Association for Retarded Children, concluded his testimony in *Wyatt v. Stickney* with the following summary:

. . . The conditions at Partlow today are generally dehumanizing, fostering

47 B. BLATT & F. KAPLAN, CHRISTMAS IN PURGATORY—A PHOTOGRAPHIC ESSAY ON MENTAL RETARDATION 22 (1966). In commenting on this book, Doctor Kugel has stated in CHANGING PATTERNS, *supra* note 20, at 4:

Recently, Blatt and Kaplan (1967) published a book entitled *Christmas in Purgatory*. In this book they indicated pictorially the deplorable state of some residential facilities. Although the authors were criticized by some, I believe that Blatt and Kaplan have performed a great and important service by pointing up this shocking problem. We all know of places where residents sit naked, surrounded by their excreta. I have seen a man without legs condemned to walk on his stumps because he once ran away from the institution, got lost, froze his legs and had to have them amputated. Everyone was reluctant to provide him with rehabilitative services for fear that there might be a repetition of this behavior, and, furthermore, his condition was perceived as a deserved punishment!

48 Complaint for Plaintiff at 11-13, *Ricci v. Greenblatt*, Civil No. 72-469F (M.D. Mass., filed Feb. 7, 1972). The gist of *Ricci* is similar to that in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala.) *formulation of minimum standards ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *implementation of standards ordered*, Civil No. 3195-N (M.D. Ala., Mar. 13, 1972), because the plaintiffs are seeking a determination that they are constitutionally entitled to adequate treatment.

deviancy, generating self-fulfilling prophecy of parasitism and helplessness. The conditions I would say are hazardous to psychological integrity, to health, and in some cases even to life. The administration, the physical plants, the programs, and the institution's articulation with the community and with the consumers reflect destructive models of mental retardation. They hark back to decades ago when the retarded were misperceived as being sick, as being threats to society, or as being subhuman organisms. The new concepts in the field of mental retardation are unfortunately not reflected in Partlow as we see it today⁴⁹

At the hearing, defendants adopted the testimony of Dr. Roos in its entirety. Other testimony at the hearing established atrocious incidents such as:

(a) a resident was scalded to death by hydrant water; (b) a resident was restrained in a strait jacket for nine years in order to prevent hand and finger sucking; (c) a resident was inappropriately confined in seclusion for a period of years, and (d) a resident died from the insertion by another resident of a running water hose into his rectum.⁵⁰

In commenting upon the foregoing, the order stated that "[e]ach of these incidents could have been avoided had adequate staff and facilities been available."⁵¹

Experience through the years throughout the country has demonstrated that reliance upon the legislature to provide solutions to the problems explicated in the foregoing cases has been misplaced. As the court in *Wyatt* stated: "The result of almost fifty years of legislative neglect has been catastrophic; atrocities occur daily."⁵²

How then are the courts to enter the arena and secure for the retarded humane living conditions and adequate treatment within the institutionalized setting? Apparently by recognition of a constitutional right to treatment or, more expansively, right to "habilitation" as developed in *Wyatt*.⁵³

B. Right to Treatment: Historical Development

The genesis of the concept of a legally enforceable right to treatment appears to be an article by Dr. Morton Birnbaum appearing in the *American Bar Association Journal*. Doctor Birnbaum argued:

It is proposed in this article that the courts under their traditional powers to protect the constitutional rights of our citizens begin to consider the problem of whether or not a person who has been institutionalized solely because he is sufficiently mentally ill to require institutionalization for care and treatment actually does receive adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible; that the courts do this by means of recognizing and enforcing the right to treat-

49 *Wyatt v. Stickney*, Civil No. 3195-N, at 4, n.7 (M.D. Ala., Mar. 13, 1972).

50 *Id.* at 8, n.13.

51 *Id.*

52 *Id.* at 8.

53 See text accompanying and following note 72 *infra*.

ment; and, that the courts do this, independent of any action by any legislature, as a necessary and overdue development of our present concept of due process of law.⁵⁴

In the same issue of the *Journal*, an editorial entitled, "A New Right," supported the concept of a right to treatment:

A precedent which held that a patient in a public mental hospital has the right to receive reasonable medical and psychiatric attention might work wonders. It could be the dawn of a new day for thousands who upon receiving better attention would be released from a madhouse to lives of usefulness. A precedent can work wonders.⁵⁵

Parenthetically, it should be noted that the authors who were advocating the right to treatment were dealing with the situation of the mentally ill as contrasted with the mentally retarded. While there are correlations between the two situations, there are also distinctions as will be hereinafter developed.

The first truly significant judicial development in the area of right to treatment occurred in *Rouse v. Cameron*⁵⁶ where a statutory right to treatment was recognized by the District of Columbia Circuit by virtue of the 1964 Hospitalization of the Mentally Ill Act. The court specifically determined that the act did provide a right to treatment which could be judicially enforced. The statements of the sponsor of the bill, Senator Ervin, played a significant role in the court's determination. The Senator had stated, in part:

Several experts advanced the opinion that to deprive a person of liberty on the basis that he is in need of treatment, without supplying the needed treatment, is tantamount to a denial of due process. [The Senate Bill] embodies provisions which will ameliorate this problem whereas existing law makes no provisions for safeguarding this right.⁵⁷

The court concluded, "[b]ecause we hold that the [statutory] right to treatment provision applies to appellant we need not resolve the serious constitutional questions that Congress avoided by prescribing this right."⁵⁸

In 1969, three years subsequent to *Rouse*, one author summarized the elements of the statutory right to treatment as developed by the District of Columbia Circuit:

(1) The hospital need not show that the treatment will cure or improve him but only that there is a bona fide effort to do so. . . .; (2) The effort [must] be to provide treatment which is adequate in light of present knowledge, [though] the possibility of better treatment does not necessarily prove that

54 Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 503 (1960). See also Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623 (1971); Birnbaum & Twersky, *Observations on the Right to Treatment*, 10 DUQUESNE L. REV. 553 (1972).

55 Editorial, *A New Right*, 46 A.B.A.J. 516, 517 (1960).

56 373 F.2d 451 (D.C. Cir. 1966).

57 *Id.* at 455; Hearings Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary Bill to Protect the Constitutional Rights of the Mentally Ill, 88th Cong., 1st Sess., at 12 (1963).

58 373 F.2d at 455.

the one provided is unsuitable or inadequate. . . . ; (3) adequate number of psychiatric personnel; (4) initial and periodic inquiries [must be] made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs.⁵⁹

The author concluded, however, that "[t]hese criteria, except for (3), are so vague that only further judicial construction may clarify their meaning."⁶⁰

Subsequent decisions of the Court of Appeals for the District of Columbia⁶¹ have further defined the right to treatment and expanded it by superimposing a constitutional right to the "least restrictive alternative" upon the statutory right to treatment. This concept of "least restrictive alternative" means, for example, that a person who is mentally ill and in need of treatment, but not dangerous, could not be confined in a maximum security hospital for the criminally and dangerously insane.⁶² The rationale for this principle is that commitment "entails an extraordinary deprivation of liberty" and that "such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law."⁶³

Support for the principle of the "least restrictive alternative" can be found in Supreme Court decisions dealing with other areas of conflict between the state and the individual, such as *Shelton v. Tucker*.⁶⁴ The Court stated, in part:

In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breath of legislative abridgement must be viewed in the light of less drastic means of achieving the same basic purpose.⁶⁵

⁵⁹ Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. CHI. L. REV. 755, 780 (1969).

⁶⁰ *Id.* Parenthetically, one reason for hesitancy in positing the existence of a right to treatment is the concern over judicial capability to enforce such a right in view of the contrariety of views as to the appropriate standards for adequate treatment and the problems of administration and funding. See 80 HARV. L. REV. 898 (1967); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967). The rebuttal to this concern is found in *Tribby v. Cameron*, 379 F.2d 104, 105 (D.C. Cir. 1967), where it was stated:

We do not suggest that the court should or can decide what particular treatment this patient requires. The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.

More recently, in effect replying to the Note in the Yale Law Journal, the Supreme Judicial Court of Massachusetts, in *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 233 N.E.2d 908, 914 (1968) stated:

We do not attempt to prescribe (see Note 77 Yale L.J. 87, 107-114) what treatment should be given to Nason. We hold as to this only that a program for Nason's appropriate treatment is to be determined by competent doctors in their best judgment within the limits of permissible medical practice . . . and is to be followed diligently.

⁶¹ *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

⁶² *Covington v. Harris*, 419 F.2d 617, 622-25 (D.C. Cir. 1969).

⁶³ *Id.* at 623.

⁶⁴ 364 U.S. 479 (1960).

⁶⁵ *Id.* at 488.

The development of the idea of a right to treatment continued with the decision of the Massachusetts Supreme Judicial Court in *Nason v. Superintendent of Bridgewater State Hospital*⁶⁶ where the court determined that confinement of mentally ill persons "without affording them reasonable treatment also raises serious questions of deprivation of liberty without due process of law." However, the most explicit stand today on the principle that the right to treatment is constitutionally mandated is found in *Wyatt v. Stickney*, where the court stated:

[A]dequate 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." *Ragsdale v. Overholser*, 108 U.S. App. D.C. 308, 281 F.2d 943, 950 (1960). The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions. . . .⁶⁷

In the first *Wyatt* decision, which was rendered March 12, 1971, the court retained jurisdiction and permitted the defendant 90 days to define the mission and functions of Bryce Hospital (apparently the inmates represented a mix of geriatric patients, mentally retarded patients and mentally ill patients) and formulate a specific plan to assure that the patients would be provided adequate treatment.⁶⁸ In the second decision, rendered on December 10, 1971, the court declared that the defendants had failed to formulate minimum medical and constitutional standards for the operation of the institutions in question. Accordingly, the court established a date for a formal hearing to permit both the parties and the various amici to present proposed standards that would "meet medical and constitutional requirements for the operation of three medical institutions herein concerned. . . ."⁶⁹

The decisions dealing with right to treatment prior to *Wyatt* have dealt with persons who are mentally ill, as contrasted to those who are mentally retarded. However, the third, and latest, decision in the *Wyatt v. Stickney* sequence dealt with conditions at the Partlow State School and Hospital, Tuscaloosa, Alabama, a public institution for the mentally retarded. After referring to the earlier decisions dealing with the mentally ill, the court stated:

In the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded. Because the only constitutional justification for civilly committing a mental retardate, therefore, is habilitation, it follows ineluctably that once committed such a person is possessed of an inviolable constitutional right to habilitation.⁷⁰

66 353 Mass. 604, 233 N.E.2d 908, 913 (1968).

67 *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

68 *Id.*

69 *Wyatt v. Stickney*, 334 F. Supp. 1341, 1344 (M.D. Ala. 1971).

70 *Wyatt v. Stickney*, Civil No. 3195-N at 4 (M.D. Ala., Apr. 13, 1972). The court quoted from the Dec. 27, 1971, resolution of the General Assembly of the United Nations entitled

C. *Right to Treatment in the Context of Mental Retardation*

Submerged within the laudable ideals embodied in the foregoing statement are two significant extensions in the development of the law in the area of right to treatment. The first extension lies in the use of the term "habilitation" rather than "treatment"; the second, in extending this right to a group which arguably, in general, is not involuntarily, but rather "voluntarily," committed.

1. HABILITATION: DEFINITION AND SCOPE

Judge Johnson's conclusion in *Wyatt* that a mental retardate has a constitutional right to "habilitation," necessarily required him to confront the task of defining the terms and enumerating those standards encompassed within the constitutional minima. This task resulted in the adoption of a document entitled "Minimum Constitutional Standards for Adequate Habilitation of the Mentally Retarded,"⁷¹ which is included as an appendix to the court's decision. The court defined habilitation as follows:

. . . the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.⁷²

Education is defined as "the process of formal training and instruction to facilitate the intellectual and emotional development of residents,"⁷³ while treatment is defined as "the prevention, amelioration and/or cure of a resident's physical disabilities or illnesses."⁷⁴

Whereas treatment had heretofore been phrased essentially in medical terms, habilitation is defined so as to expressly extend to education. Whereas treatment, overlaid with the principle of the "least restrictive means," could require transfer from a maximum security institution to a general psychiatric institution, the concept of habilitation—as further defined and extended in the appendix to the *Wyatt* decision—encompasses the nature of the living conditions within an institution such that overcrowding and sanitation may be effectively brought before a court, together with the questions as to whether each patient has an individualized plan, is enjoying a humane physical and psychological environment, is

"Declaration on the Rights of the Mentally Retarded" in support of this statement. The resolution read as follows:

. . . The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

Id. at 4, n.6.

⁷¹ These standards are set forth in the Appendix to this article. The standards were formulated from the "Standards for Residential Facilities for the Mentally Retarded," adopted May 5, 1971, by the Accreditation Council for Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals, Chicago, Illinois.

⁷² *Wyatt v. Stickney*, Civil No. 3195-N, at 11-12 (M.D. Ala., Apr. 13, 1972).

⁷³ *Id.* at 12.

⁷⁴ *Id.*

receiving adequate medication, diet, and clothing, and is attended by adequate staff, both in terms of quality and numbers.⁷⁵

Rather than summarizing the provisions of the standards set forth in the appendix to the court's decision, such appendix is attached to this article in order to permit the reader to appreciate for himself the breadth of the concept of adequate habilitation. In order to put the need for judicial implementation to such a concept into perspective one need only review the authorities earlier referred to which set forth the gross inadequacies in the present treatment of the mentally retarded.⁷⁶

It can hardly be gainsaid that once a right to treatment is recognized, the extension embodied in the concept of habilitation is a natural one, particularly in the mental health area since the psychological and physical environment is intimately a part of the treatment process. On the other hand, the extension of the right to treatment from those mentally ill to those mentally retarded does raise some conceptual legal problems which will now be examined.

2. SIGNIFICANCE OF VOLUNTARY ADMISSION

As noted above, the premise upon which the right to treatment is based is that the state, for the well-being either of the patient or society, has withdrawn the patient from society, thereby depriving him of his liberty, and placed him in an institutional setting for treatment. The fourteenth amendment covers state action, not private action,⁷⁷ so it is necessary that there be participation by the state in such deprivation of liberty in order that a constitutional claim may be stated. Such state involvement is not difficult to discover in the mental illness area since substantial numbers of those mentally ill have been involuntarily committed to public institutions via civil commitment proceedings.⁷⁸ While most state statutes also provide for so-called "voluntary" admission procedures pursuant to which a patient may also "voluntarily" leave, overhanging such "right to leave" is the possibility of a civil commitment proceeding being commenced by the administrator in the event the patient determines to avail himself of the opportunity to leave the institution.⁷⁹ In fact, it has been argued in the mental illness area that there is in fact no such thing as a voluntary commitment to a state mental hospital.⁸⁰

Conversely, in the mental retardation area, the overwhelming majority of the patients are either children or those who were institutionalized while they were children. The admission of these persons to institutions for the mentally retarded is arguably voluntary since the substituted consent of the parent or

⁷⁵ *Id.* at 12-14.

⁷⁶ See text accompanying and following note 45 *supra*.

⁷⁷ *Reitman v. Mulkey*, 387 U.S. 369 (1967); Black, *The Supreme Court 1966 Term—Foreword: "State Action," Equal Protection and California's Proposition 13*, 81 HARV. L. REV. 69 (1967).

⁷⁸ S. BRAKEL & R. ROCK, *supra* note 42, at 17. In 1968, about 60 percent of admissions were involuntary.

⁷⁹ *Id.* at 22-25, 461, 471-72.

⁸⁰ Gilboay & Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 452 (1971).

guardian was obtained when the person was admitted. The logical conclusion from such an argument is that the presence of the retardate in the institution can give rise to no constitutional right to treatment predicated upon deprivation of liberty because the patient is free to leave at any time. The logic of such a proposition, of course, ignores the fact that many of the retarded in institutions are not capable of living outside a sheltered environment⁸¹ and that the right to leave in this context is just as illusory as in the area of mental illness.

D. Legal Bases for Right to Treatment

The question then arises as to what legal responses may rebut the argument that the right to treatment should not be extended to the mentally retarded, at least those who are purportedly voluntary admittees. There appear to be several possible approaches.

1. PARENS PATRIAE

One approach is to rely upon the doctrine of *parens patriae*.⁸² It may be argued that once the state steps into the role of the parent and assumes custody of the child, it is bound to furnish the child such care and treatment as is required of the parents themselves. Indeed, there may well be a statutory requirement that the state furnish adequate care and treatment.⁸³ Failure to discharge such duty whether imposed upon the state by statute or as part of the common law, could result in the deprivation of the retarded child's liberty without due process of law. Granted that this is not the usual type of situation at which the due process clause is directed; it is normally applicable only when the state is acting hostilely to the individual, and not in a paternal capacity. However, *In re Gault*⁸⁴ indicates that when the liberty of the child is at stake, the state may not use the cloak of *parens patriae* to shield it from the standards imposed by the fourteenth amendment and consequent judicial scrutiny.

But there is still a further problem in relying upon the doctrine of *parens patriae* since this doctrine is normally applicable only when the state is acting in

81 This is not to suggest that all retarded should be institutionalized; quite the contrary. As stated in *Wyatt v. Stickney*, Civil No. 3195-N, at 13, n.2 (M.D. Ala., Apr. 13, 1972), "it is contemplated that no mildly retarded persons be residents of the institution." On the other hand, the severely and profoundly retarded are not capable of being self-supporting. Even in this situation, home care at least for the young child is favored. See R. ALLEN, *supra* note 16, at 13-14. However, where a home environment is not available because the parents, for physical, economic, psychological or less justifiable reasons, cannot or will not care for the child, the state must then be prepared to furnish the sheltered environment pursuant to its responsibility under the doctrine of *parens patriae*.

82 For background on this legal concept see note 31 *supra*.

83 See, e.g., IND. STAT. ANN. §§ 22-1703, 22-1735 (1964).

22-1703. The purposes of this institution shall be to care for, support, train and instruct feeble-minded children, the term "feeble-minded" to include idiotic, epileptic and paralytic children.

* * *

22-1735. It shall be the duty of the trustees and the superintendent, as far as the means provided will admit, to cause the pupils of said school to be so trained and educated as to render them better fitted to support and care for themselves, and provide, as far as possible, for the physical, intellectual and moral improvement of said pupils.

84 *In re Gault*, 387 U.S. 1, 16-17, 26-27 (1966).

lieu of the parent. In the mental retardation area, however, the state is often acting for the parent; in other words, it could be argued that the state is making available a facility, possibly in the exercise of its proprietary, as contrasted to governmental powers,⁸⁵ for which service the parent pays a fee.⁸⁶ If the state is not *obliged* to provide such a service, there could be two consequences. An increase in the standard of care provided by the institution would also increase the costs. The state could then either raise the fee it charges to the parents or remove itself from the business of providing to the mentally retarded institutional facilities for the benefit of the parents. Neither of these results would be particularly happy; fortunately, they are extremely unlikely.⁸⁷

2. IMPOSSIBILITY OF A "VOLUNTARY" COMMITMENT

A better approach is to argue that there are no voluntary inmates in an institution for the mentally retarded. *A priori*, the retardate cannot consent to his institutionalization. The question then becomes of what legal efficacy is the substituted consent of the parent in determining the voluntariness, from the retardate's standpoint, of his restraint. As noted earlier, there is often a conflict of

85 *But see* text accompanying note 104 *infra* as to the arguably governmental character of the operation of such institutions.

86 *See, e.g.,* IND. STAT. ANN. § 22-1726 (1964):

Any persons who wish to enter a child into said institution for treatment, training, culture or improvement, and pay all the expenses and furnish attendant, may do so under agreement, rules and regulations prescribed by the superintendent and approved by the trustees. Under this section adults may be admitted under rules adopted by the trustees, if their entire support and maintenance is provided for by some friend or other person.

See also IND. STAT. ANN. § 22-1808 (1964). The general approach as to the allocation of cost in caring for a retardate in an institution has been characterized as follows:

The general rule in the United States with respect to the ultimate obligation for the payment of expenses for retardates residing in state institutions can be stated as follows: either the state alone or the state together with the county of residence is responsible for the care of the institutionalized mentally retarded, subject, in all but three states to partial or complete reimbursement from the patient himself, his estate, parents, spouse and/or children. Since almost 85 per cent of all first admissions are under 20 years old, few ever marry, have children or have any opportunity to earn money to pay for their own care. As a consequence, parents represent over 99 per cent of all liable relatives actually contributing toward the cost of institutionalization. Maximum legal monthly charges for liable relatives in 1966 ran the gamut from \$525 in one institution in Rhode Island to lows of \$5 in West Virginia, \$16.34 in Minnesota and \$20 in California. The median was \$120. In all 47 states requiring payment by the patient or responsible relatives this obligation is ameliorated by the "ability to pay" doctrine, which bases the charge to the obligor upon what he can afford to pay.

Knudsen, *Mental Retardation—Who Shall Pay the Bill for Resident Care in Public Institutions?*, 3 FAM. L. Q. 331, 333-34 (1969).

87 The possibility of the parents bearing the brunt of increased costs is rendered unlikely by the "ability to pay" doctrine. Knudsen, *Who Should Pay the Bill for Resident Care in Public Institutions?*, *supra* note 86. Knudsen argues that the Equal Protection Clause bars any obligation to pay imposed on the parent. *Id.* at 340-43. This author concurs that parents should not be obligated to pay and would hope that enlightened legislatures would relieve parents of this financial burden. The underlying rationale is akin to that of casualty insurance. Nobody expects their home to burn down; but it does happen and the resulting burden may be catastrophic if borne by the family in question. So the risk is spread among the many to make it more bearable. Similarly, no one anticipates a retarded child. An enlightened social policy could also diffuse the financial burden in this situation, particularly in view of the emotional burdens which the family must continue to bear. Since there is no mortgagee to exert pressure to carry private insurance, government should in effect act as the insurer.

As to the likelihood that a state could decline to furnish facilities for those of the retarded who need an institutional setting, *see* text accompanying note 104 *infra*.

interest between parent or child in situations involving the mentally retarded. This is particularly true where institutionalization is involved. As one authority has stated:

Our laws seems to operate on the premise that institutionalization is for the benefit of the child; indeed many urge that institutionalization on parental application should be made as easy as possible. Yet, it would seem that a great many children are institutionalized less for their own benefit than for the comfort of others. Because it is believed that the retarded—including retarded children—do indeed have “rights,” the author would be inclined to differ with the Task Force on Law of the President’s Panel on Mental Retardation, and require judicial approval in any case in which institutionalization is based not on the needs of the child but on the needs of others, in order that appropriate resolution may be made of the perhaps conflicting interests of the child and his family, and that use of alternatives to residential care may be explored.⁸⁸

In fact, the parents’ decision to ask for institutionalization of the child may not be a truly voluntary decision:

Indeed, it may well be that the parent’s request for admission of a retarded child may not be a truly voluntary decision by the parent where his economic or physical and emotional resources have been exhausted and there is insufficient supportive help in the community to aid him in keeping the retardate at home.⁸⁹

With respect to the question of the “voluntariness” of a retarded person’s presence in an institution, there is some recent case law support for the idea that neither the parent nor the child is capable of consenting to a situation which may not be in the best interests of the child.⁹⁰

In *Frazier v. Levi*,⁹¹ the court considered an application filed by the mother and guardian of the person and estate of a 34-year-old retardate which sought an order authorizing an operation which would have rendered the retardate sexually sterile. The girl was apparently promiscuous and already had two children, both of whom were also mentally retarded, for whom she was not capable of caring. The court denied the application due to the lack of statutory authority for such action:

As a mentally incompetent person, the ward lacks the mental capacity to consent to the operation or to oppose it. Her legal rights are to be carefully protected and must not be taken from her without due process of law even though her natural mother and guardian feels that the operation would benefit all.⁹²

88 R. ALLEN, *supra* note 16, at 14.

89 Wyatt v. Stickney Amici Brief, *supra* note 18, at 35, n.9.

90 *Frazier v. Levi*, 440 S.W.2d 393 (Tex. App. 1969); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. App. 1969). It is assumed that institutionalization in a situation which would generate legal action seeking recognition of a right to treatment is an instance not in the best interest of the child.

91 440 S.W.2d 393 (Tex. App. 1969).

92 *Id.* at 394.

In another recent decision, *Strunk v. Strunk*,⁹³ the Court of Appeals of Kentucky, in a four-to-three decision, permitted the transplant of a kidney from a mentally retarded 27-year-old individual to his "normal" 28-year-old brother. The majority opinion assumed, and the dissent noted, that the family was not privileged to authorize the removal of the kidney. However, the majority determined that a chancery court does have sufficient inherent power to authorize the operation, based upon evidence that such operation would be in the best interest of the incompetent. Testimony established that the two brothers had a very close relationship and that the death of his brother would be a severe psychological blow to the retardate.⁹⁴

Removal of a kidney certainly is no more a serious threat to life and liberty than are the deplorable conditions in many institutions. Accordingly, if parents may not consent to a kidney operation, their consent to institutionalization in a warehouse-type institution certainly should not operate to absolve the state from providing minimal standards of habilitation for the retardate while institutionalized.

3. EQUAL PROTECTION

Another approach in securing the right to treatment in an institutionalized setting for the mentally retarded is through the equal protection approach. That equal protection considerations may be applicable in the right to treatment area was recognized by the Massachusetts Supreme Judicial Court in *Nason*. The court determined:

[I]f such treatment is not available on a reasonable, nondiscriminatory basis, there is 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.⁹⁵

The Supreme Court has already utilized the equal protection clause in the mental health area to strike down an unreasonable classification. In *Baxstrom v. Herold*,⁹⁶ the Supreme Court considered a New York statute which permitted civil commitment at the expiration of a penal sentence without the jury review which is available in other types of civil commitment proceedings. In declaring the statute unconstitutional, the Court noted:

The director contends that the State has created a reasonable classification differentiating the civilly insane from the "criminally insane," which he defines as those with dangerous or criminal propensities. Equal protection does not require that all persons be dealt with identically, but it does require that a distinction made have some relevance to the purpose for which the classification is made. . . . Classification of mentally ill persons as

93 445 S.W.2d 145 (Ky. App. 1969).

94 *Id.*

95 *Nason v. Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908 (1968).

96 383 U.S. 107 (1965).

either insane or dangerously insane of course may be a reasonable distinction for purposes of determining the type of custodial or medical care to be given, but it has no relevance whatever in the context of the opportunity to show whether a person is mentally ill *at all*. For purposes of granting judicial review before a jury of the question whether a person is mentally ill and in need of institutionalization, there is no conceivable basis for distinguishing the commitment of a person who is nearing the end of a penal term from all other civil commitments.⁹⁷

Similarly, when two individuals are residing in a state institution for the mentally retarded, one of whom has been civilly committed⁹⁸ and the other "voluntarily admitted,"⁹⁹ there is no reasonable basis upon which to grant one the right of habilitation which, as previously stated, includes a humane physical and psychological environment, education, and adequate medical care, and not grant a comparable right of habilitation to the other individual. While each may have differing medical or educational needs, both are entitled to an adequate medical and psychological response to those needs. The method by which a mentally retarded person is admitted to an institution has nothing to do with the general need for treatment and decent living conditions while residing in such institution. Accordingly, if an institution has both voluntarily and involuntarily committed residents, due process will compel constitutional standards of habilitation for the involuntarily committed retardate and equal protection will compel the extension of the same standards to the voluntarily admitted or committed retardate.

But what if there is a state institution with only voluntary admittees? In such a situation we will need to look to other institutions for a basis of comparison to see whether there is a reasonable basis for differing standards at the two institutions. If there is another state institution for the mentally retarded who are involuntarily committed, we again have available the argument set forth in the previous paragraph.

If there is no state institution which numbers among its residents involuntarily committed retardates (which is quite unlikely), we will need to switch the basis of comparison to institutions for the mentally ill which must constitutionally provide habilitation because of the involuntary commitment procedure generally involved. Here the equal protection argument is somewhat more tenuous because of the substantial differences in needs, capabilities, and future prospects between the mentally ill and the mentally retarded. Nonetheless, in neither case should

97 *Id.* at 111-12 (emphasis in original); see also *Jackson v. Indiana*, 406 U.S. 715 (1972) where the Court held in part that the Equal Protection Clause barred continued restraint of a mentally retarded defendant who was incompetent to stand trial unless such confinement was pursuant to proper civil procedures.

98 See, e.g., IND. STAT. ANN. § 9-3220 (1956), which provides with respect to a neglected or delinquent child:

If it shall appear that any child concerning whom a petition has been filed is mentally defective or mentally disordered, the court, before committing him to an institution, shall cause such child to be examined by two [2] qualified physicians and on their written statement that such child is mentally defective or mentally disordered, the court may commit such child to an appropriate institution authorized by law to receive and care for any such child. The parent, guardian or custodian shall be given due notice of any proceedings hereunder.

99 Assuming, however, that there is in reality such a concept as a voluntarily admitted retardate. See text accompanying and following note 93 *supra*.

the state be able to retain an individual in custody under conditions which affront human dignity.

A better basis for comparison might be between state and private institutions. If the state, under its police power to provide for the health and welfare of its citizens, establishes minimum standards for private institutions,¹⁰⁰ can it logically argue that the state is entitled to provide any lesser standard in its own institutions?¹⁰¹

A final possibility which should be considered is the effect of a determination by a state to remove itself from the business of providing facilities for voluntary admittees who are mentally retarded. While it is extremely remote that any state might so decide, we still may inquire as to whether there is any remedy available for the retarded in such a situation. Since all states have furnished such facilities and it is clear that certain classifications of the retarded are not capable of existing except in a sheltered environment, it could be argued that the state, through its past practice, has recognized the critical need of certain classes of its citizens for an institutionalized setting and that for a state to deprive the citizens of such a setting would be a deprivation of their liberty pursuant to the fourteenth amendment.¹⁰² In other words, we would have the anomalous situation that for certain groups of citizens to enjoy their liberty (or more specifically, to enjoy life) a certain deprivation of liberty in the usual sense is necessary because realistically they can only function in a state supported and sheltered environment.

¹⁰⁰ See, e.g., IND. STAT. ANN. § 22-5032(3) (1964); IND. AD. RULES AND REG. § 22-5032-1 *et seq.* (1967).

¹⁰¹ This could be a two-edged sword: not only could it be argued that state institutions must meet "private" hospital standards, but also the converse; that "private" hospitals must meet the standards constitutionally mandated in state institutions. It has been recognized that "private" hospitals are entwined with state action and this may be subject to equal protection and due process strictures. *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964); *Reitman v. Mulkey*, 387 U.S. 369, 385-86 (1967) ("Urban housing, like . . . hospitals, is effected with a public interest in the historic and classical sense." See also *Evans v. Newton*, 382 U.S. 296, 299 (1966): "Conduct that is formally private may become so entwined with governmental policies or so impregnated with a governmental character as to become subject to constitutional limitations placed upon state action").

¹⁰² *Reitman v. Mulkey*, 387 U.S. 369 (1967), which held unconstitutional the California Constitutional Amendment forbidding the state to enact "open occupancy" laws and repealing those in existence, could be interpreted as holding that once the state has acted to create a "right," it cannot in the future withdraw such right from prospective beneficiaries. See Black, *The Supreme Court 1966 Term—Foreword: "State Action," Equal Protection and California's Proposition 13*, *supra* note 77, at 73.

However, this would egregiously overstate the *Reitman* holding. It is noteworthy, though, that Professor Black, in discussing this case, indicated his preference for an expansive interpretation of "state action" and stated a position which is particularly relevant to the situation of the retarded:

When a racial minority is struggling to escape drowning in the isolation and squalor of slum-ghetto residence, everywhere across the country, I do not see why the refusal to throw a life preserver does not amount to a denial of equal protection.

Id.
Later, in drawing an analogy to the extension of the commerce clause which reached its zenith in *Wickard v. Filburn*, 317 U.S. 111 (1942), he suggested that where equal protection is concerned there can be "no principled stopping-place" less than this:

If one race is, identifiably as such, substantially worse off than others with respect to anything with which law commonly deals, then "equal protection of the laws," is not being extended to that race unless and until every prudent affirmative use of law is being made toward remedying the inequality. *Id.* at 97.

There is both statutory and case law support for this position. For example, Indiana has recognized its obligation by statute:

There shall be established in this state a farm colony for the feeble-minded. In the establishment of this institution, the general assembly recognizes the duty of the state to provide care for such of its citizens as are feeble-minded, and are therefore unable properly to care for themselves.¹⁰³

Also there has been judicial recognition that the operation of mental hospitals is a governmental function¹⁰⁴ and that the state has no realistic option to discontinue them:

The discontinuance of the State mental hospitals for those needing care and unable to pay, and the discontinuance of the correctional schools would seriously adversely affect the public interest and welfare of the State. If the State ceased to perform such services, it is unlikely that private enterprise would step in to fill the need.¹⁰⁵

The same rationale holds true with respect to institutions for the mentally retarded, perhaps with even more force. While institutionalization of a mentally ill person is, hopefully in many situations, a short term arrangement for which the affected individual could pay upon his return to a fully productive life, mental retardation is not, strictly speaking, curable (though its effects can be ameliorated and the level of functioning greatly improved).¹⁰⁶ Accordingly, for many of the more seriously retarded, institutionalization (though not necessarily in a warehousing arrangement)¹⁰⁷ is a lifetime proposition. Under such circumstances, where the capital investment is extremely high and the capability of the consumer to pay is extremely restricted, it is inconceivable that private enterprise can furnish the services.

IV. Financial Impact of Recognition of Rights

It should be obvious to the reader at this point that the concept of a constitutional right to treatment or habilitation will be expensive. As a matter of fact, to provide the present inadequate treatment is costing over \$500 million dollars a year and the cost to continue such treatment is expected to rise considerably.¹⁰⁸

¹⁰³ IND. STAT. ANN. § 22-1801 (1964).

¹⁰⁴ *Employees of Dep't of P.H. & W. v. Department of P.H. & W.*, 452 F.2d 820, 827 (8th Cir. 1971), cert. granted, 405 U.S. 1016 (1972).

¹⁰⁵ *Id.* at 826.

¹⁰⁶ See text accompanying notes 145-49 *infra*.

¹⁰⁷ See note 120 *infra*.

¹⁰⁸ In early 1967, we were spending at a rate of \$600 million a year for about 200,000 institution residents. However, merely to maintain the standards and rate of current institution services will require a rapid rise in institutional costs. By 1975, we could be spending \$2 billion a year on our institutions, and they could still be most inadequate. That this is a strong possibility is underlined by the fact that some public institutions with the highest per diem expenditures in this country are grossly dehumanizing.

CHANGING PATTERNS, *supra* note 20, at 145. While the expenditure of this sum of money may appear substantial, in reality it is grossly inadequate:

About 200,000 adults and children currently reside in public institutions for the

Unquestionably, however, the fact that recognition of a right may be expensive is no reason to deny the existence of that right. As the Court of Appeals for the District of Columbia has stated, a need for additional funds ". . . is no reason for the court to refrain from declaring that the obligation exists. . . ." ¹⁰⁹ Similarly, in *Hoosier v. Evans*,¹¹⁰ the court rejected an argument that a class of alien children could be excluded from the public school system because of inadequate funds:

. . . fundamental rights guaranteed by the Constitution may be neither denied nor abridged solely because their implementation requires the expenditure of public funds. For such purposes, the Government must raise the funds.¹¹¹

The Supreme Court itself, in *Shapiro v. Thompson*,¹¹² where state minimum residence requirements for welfare benefits were invalidated, has stated:

We recognize that a State has a valid interest in preserving the fiscal integrity of its program. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes of its citizens. It could not, for example, reduce expenditures for education by barring indigent children from its schools.¹¹³

It is naive to believe, however, that the question of cost will not be lurking in the back of the minds of judges and legislators when the question of constitutional

retarded in this country, at a cost of about \$500,000,000 a year in operating expense alone. At first glance, this appears to be a great deal of money and, to the unknowing laymen, is cause for comfort, i.e., the mentally retarded have finally received their due. However, simple arithmetic tells us that \$500,000,000 divided by 200,000 amounts to \$2,500 a year, or about \$48 per week or \$7 per day. This is about one-eighth the amount spent for a day's general hospital care. Four states spent less than \$4 per day in 1966. In some checking that I have done recently, I learned that in our better zoos, the larger animals require a higher per capita expenditure.

The average per capita daily cost for maintaining a retarded resident in each of the four institutions I described was, at that time, less than \$7, in one case less than \$5. In contrast, The Seaside, a new regional center for the retarded, sponsored by the Connecticut Department of Health and discussed in our aforementioned book, *Christmas in Purgatory*, spent \$12 daily for care and treatment of each resident. Although it may be true that money corrupts, it may be equally true that its absence is similarly corrupting.

Id. at 40-41.

¹⁰⁹ *Doe v. General Hospital of the District of Columbia*, 434 F.2d 427, 433 (D.C. Cir. 1970).

¹¹⁰ 314 F. Supp. 316, 320 (D.V.I. 1970).

¹¹¹ *Id.* at 320.

¹¹² 394 U.S. 618 (1969). Parenthetically, the court in *Wyatt v. Stickney*, Civil No. 3195-N (M.D. Ala., Apr. 13, 1972) took a subtle approach to the question of funding. The decision recited the fact that plaintiffs have moved for an injunction against the expenditure of state funds for nonessential functions of the state until enough money is available to provide adequately for the institutions in question and asked the court to order a sale of a portion of the Mental Health Board's landholdings and other assets. The Decree stated that the Court reserved the right to rule on plaintiffs' motion and that if "the Legislature fails to satisfy its well-defined constitutional obligation and the Mental Health Board because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps including appointing a master, to insure that proper funding is realized and that adequate habilitation is available for the mentally retarded of Alabama." *Id.* at 8. One might characterize this as the "velvet glove approach."

¹¹³ *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969).

minimum standards of habilitation is brought before them. Unquestionably, the increase in quality will have an upward thrust on cost; however, at least from a long-run standpoint, there is no reason why a reduction in quantity cannot have a commensurate downward thrust on the overall cost of providing services for the retarded.¹¹⁴ "Even though fewer than five percent of the mentally retarded in the United States reside in institutions, more money is spent to maintain them than is spent for any of the public programs which serve the remaining 95 percent."¹¹⁵

Probably the most telling argument for recognizing the rights of the retarded is the following statement:

In fact, of every 30 retarded children, 25 with education, are capable of achieving self-sufficiency in the sense of entering the ordinary labor market. Another 4, with education, are also capable of achieving self-sufficiency, though in employment in a sheltered environment. And one, with education, is capable of achieving self-care.¹¹⁶

No doubt, most people would be surprised by the foregoing statement. This is primarily because "the general population (including lawyers) views all retarded persons as being nearer the low end of the scale."¹¹⁷

114 The pressures on institutions from a numerological standpoint is illustrated in the following excerpt:

More than 200,000 people, nearly half of whom are children, now live in over 150 public institutions for the mentally retarded in the United States. Another 20,000 retarded reside in approximately 500 known private facilities. Tens of thousands more wait out their times in institutions for the mentally ill; nearly 10 percent of all residents in public mental hospitals are retarded.

The number of institutionalized mentally retarded increases by over 3,000 every year. Public institutions for the mentally retarded alone admitted an average of over 15,000 every year between 1960 and 1967. Over half of these were under ten years of age. An average of only 8,000 was released from public institutions each year from 1960 to 1967, and approximately 3,000 died while institutionalized during each of those years. Accurate statistics concerning trends in the numbers of retarded residents in private institutions and in public facilities for the mentally ill are not available. Estimating from the number of retarded people in these facilities, they probably accommodate an additional 300 to 400 retarded each year over and above the more than 3,000 who are annually added to the rolls of public facilities for the retarded.

CHANGING PATTERNS, *supra* note 20, at 17.

115 *Id.* at 18.

116 Plaintiffs' Memorandum in Support of Their Motion to Convene a Three Judge Court, at 6, Pennsylvania Ass'n. For Retard. Child. v. Commonwealth of Pa., 334 F. Supp. 1257 (E.D. Pa. 1971). Also in THE PRESIDENT'S COMMITTEE ON MENTAL RETARDATION MR69 17 (1969) [hereinafter cited as MR69] the authors stated:

Perhaps the most overlooked resource of all in the mental retardation field is . . . the retarded themselves. Some three-quarters of this nation's retarded people could become self-supporting if given the right kind of training early enough. Another 10 to 15 percent could be partially self-supporting.

117 Haggerty, Kane and Udall, *An Essay on the Legal Rights of the Mentally Retarded*, *supra* note 1, at 65. The authors, two of whom are members of the President's Committee on Mental Retardation and the other who is a consultant thereto, support the aforesaid mentioned statistics on the self-sufficiency capability of the mentally retarded:

The major point of differences in the levels of retardation is that while the profoundly retarded may have to remain in institutions during their entire lives, the others are educable to a surprising degree. The moderately retarded can be taught to take care of themselves physically and can learn some manual skills. Though the moderately retarded cannot master formal school work, the mildly retarded can reach the sixth grade and can also learn to do and to hold *simple* jobs.

There is quite a difference, then, between the reality of a retarded person's ability to learn and perform certain tasks and the general public's expectations.

The solution, then, or part of the solution, to the rising costs of institutionalization¹¹⁸ is to insure that education and training are available to those significant numbers of the mentally retarded who are capable of being self-supporting or at least of existing in an environment less oppressive (and costly) than the total care custodial-type warehousing institutions so prevalent today.¹¹⁹ "Few retardates need hospital treatment; all need education, employment, a satisfying social and cultural environment, and, in the case of retardates who cannot live with their own families, a home in which they can live as normal a life as possible."¹²⁰

The significance of education in reducing the overall cost of the care of the retarded has been well recognized by Dr. Marvin A. Wirtz, Deputy Commissioner

118 Another facet to the solution of reducing the cost of retardation is to eliminate that retardation which develops from environmental factors. The PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, MR 71 5 (1971) has focused upon this problem:

It is no coincidence that in isolated rural areas and crowded city slums where the incidence of mental retardation is abnormally high, there is also an unusually high rate of malnutrition, illness, unsanitary conditions, inadequate housing, accidents, lack of health, care and education, and pervading apathy of poverty.

The report continues:

Children of the poor are about ten times more likely to be retarded than children of the middle and upper classes. If the children of all population groups had the same rate of mental retardation as those of middle and upper class whites, the prevalence of retardation would decrease by 80 per cent.

Id. at 27.

119 As Judge Johnson has stated in *Wyatt v. Stickney*, Civil No. 3195-N, at 13, n.2 (M.D. Ala., Apr. 13, 1972), "it is contemplated that no mildly retarded persons be residents of the institution." Yet 18 percent of the residents of institutions are either mildly or borderline retarded, while another 22 percent are moderately retarded. Thus, 40 percent of our institutional population could be more or less self-supporting (see the following table). *Supra* note 20, at 20.

Levels of Retardation	Distribution of Residents According to Level of Retardation	
	Number of Residents	Percent
Profound	51,973	27
Severe	63,523	33
Moderate	42,348	22
Mild	25,024	13
Borderline	9,625	5
	192,493	100

CHANGING PATTERNS, *supra* note 20, at 20; *see also id.* at 24, 27.

120 CHANGING PATTERNS, *supra* note 20, at 205. The author also discusses the various residential alternatives to institutions and compares the costs in building and operating the large multi-purpose institutions, which characterize the approach in the United States, with the smaller, single purpose foster homes and small hostels upon which the emphasis is in Europe. Moreover, the author concludes that the smaller facility, besides providing a more humane environment, may also be cheaper from an overall standpoint. *See also id.* at 211-26.

A step in the right direction was taken by Indiana when it enacted a law entitled "An act to initiate the development of demonstration community residential models for the mentally retarded." Pub. L. No. 237 (Feb. 17, 1972). The preamble to this act reads:

Whereas, The state of Indiana is striving to provide a most adequate system of programming for the mentally retarded; and

Whereas, Placement of a mentally retarded individual by the department of mental health in one of the state institutions is often not in the best interest of the individual for potential growth;

Section 1 provides:

It is the intent of the state of Indiana to develop through leasing a variety of needed community residential facilities for the mentally retarded. These facilities will relate to the full range of community programs and resources.

of the U.S. Office of the Education Division for the Disadvantaged and Handicapped, Department of Health, Education and Welfare who testified before the Maryland Governor's Commission as to the amount of money which "would be saved for the taxpayers in a community by educating a child as opposed to allowing him to become a ward of the State."¹²¹ The savings are two-fold: First, savings would result from the decrease in costs of educating a child for 12 years, as opposed to supporting him in an institution for his life-time; second, "savings" would result from his productivity in working in a sheltered workshop during his adult life. Dr. Wirtz has estimated the total savings as approximating \$178,000 for one individual.¹²² He concluded his testimony as follows:

This is the approach I have used for the "so-called" hard-headed businessman who wants to know why we are spending so much money on "these kids when they aren't going to amount to anything anyway." To me, the answer is very clear. *This country can no longer afford to avoid its responsibilities for educating the handicapped either in financial or moral terms.*¹²³

Consequently, in order that many of the retarded may obtain full or partial self-sufficiency and that the long term pressure on the state's financial resources may be reduced, it is necessary that educational and training programs generally be made available to the retarded. This logically leads to the third question raised in this article, namely, to what extent are the retarded constitutionally entitled to an education within the public school system?

V. Education

There is no question that today substantial numbers of retarded children are denied the right to an education. In 1969, the President's Committee on Retardation estimated that approximately sixty percent of the school age children who are retarded are not receiving an education.¹²⁴ An earlier study, which dealt with all handicapped children and not just the mentally retarded, estimated that seventy-five percent of these children were not receiving an education.¹²⁵

121 1966 REPORT OF THE GOVERNOR'S COMMISSION TO STUDY THE EDUCATIONAL NEEDS OF HANDICAPPED CHILDREN IN MARYLAND 27 [hereinafter cited as 1966 MARYLAND REPORT].

122 Dr. Wirtz testified as follows:

Assuming that it costs \$1,000 to educate a retarded child and he is kept in school for twelve years, this would be an expenditure of \$12,000 on the part of the taxpayers. If, however, he entered a State institution at age 15 and stayed there until he was sixty-five, he would have spent fifty years in an institution with an average cost of \$2,000 a year based on current spending. This would be an expenditure of \$100,000 or a net difference of \$88,000 in cost. Add to this the fact that if the person were trained to work in a sheltered workshop and work for poverty wages for a period of time that he finished school until he was sixty-five, which we might assume is forty-five years, he would have earned \$90,000. If this is added to the \$88,000 already saved, there is a net saving of about \$178,000 on one individual.

Id.

123 *Id.* at 28 (emphasis added).

124 MR 69, *supra* note 116, at 18.

125 1966 MARYLAND REPORT, *supra* note 121, at 3. The report stated:

Only about one-fourth of these six million handicapped children are registered in special education programs in public or private schools throughout the country.

While the situation is improving,¹²⁶ "more battles will have to be waged against a system that still fails to educate its children."¹²⁷

A. *Equal Protection in the Educational Context*

What legal weapons are available to insure that all children have the opportunity to receive a public education adapted to their particular needs? The answer to this question lies in the application of the equal protection clause to the present uneven and discriminatory availability of public educational programs for the mentally retarded.

The basic principles governing the application of the equal protection clause have already been discussed in the context of institutionalization.¹²⁸ Such principles have recently been reiterated by the Supreme Court:

In applying that clause, this Court has consistently recognized that the fourteenth amendment does not deny to the States the power to treat different classes of persons in different ways. . . . The Equal protection Clause of that amendment does, however, deny to States the power to legislate that different treatment be accorded to persons placed by a statute in the different classes on the basis of criteria wholly unrelated to the objective of that statute. A classification "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike."¹²⁹

The question under the equal protection clause, then, is whether a classification which excludes some or all of the mentally retarded children in the public educational system is a reasonable classification which rests upon some grounds having a fair and substantial relation to the object of the legislation.

All states have established public systems of education which are generally available—indeed, attendance is mandated—for all school-age children, absent some basis for exclusion.¹³⁰

Obviously, there is a difference in status between "mentally retarded" and "normal" children—witness the fact that in discussing the education of the mentally retarded we are often talking about "special education" programs. But is this difference so great that it will justify a state either to refuse to adopt special education programs for the benefit of the mentally retarded or, if it does adopt such

¹²⁶ According to Weintraub, *Recent Influences of Law on the Identification and Placement of Children in Programs for the Mentally Retarded*, 4 (unpublished manuscript on file at the NOTRE DAME LAWYER):

By 1948, 1,500 school systems reported special education programs, 3,600 in 1958, and 5,600 in 1963. Mackie (1965) reported that as many as 8,000 school districts contracted for special education services from neighboring districts. Today it is estimated that 2,252,000 handicapped children are receiving special education services, 600,000 of whom are considered mentally retarded. Of all handicapped children receiving services . . . about 25% are black, Mexican, American, Puerto Rican, or Indian.

¹²⁷ *Id.*

¹²⁸ See text accompanying note 94 *supra*.

¹²⁹ *Reed v. Reed*, 404 U.S. 71, 75-76 (1971).

¹³⁰ *Brown v. Board of Education*, 347 U.S. 483, 493 (1954).

programs, limiting the scope of these programs so that certain classes of the mentally retarded (the "severely and profoundly" retarded or the "trainable," for example) are excluded from participation in these programs? To answer this question, it is necessary to look at the status of education as viewed through the eyes of the courts and the capability of all the mentally retarded to benefit from education as viewed through the eyes of the professionals in the field of mental retardation.

1. EDUCATION AS A FUNDAMENTAL INTEREST

It is necessary to look at education generally, and its significance to the child and society, because of the two-fold approach which the courts have taken in determining whether a classification established by the legislature is reasonable. Normally, a classification will be upheld if the legislation is not arbitrary and fulfills a legitimate governmental purpose and is rationally related to that purpose.¹³¹ On the other hand, "where fundamental rights and liberties are asserted under the equal protection clause, classifications which might invade or restrain them must be closely scrutinized and carefully confined."¹³² In other words, a more exacting standard of review of the reasonableness of the classification will be applied when a fundamental interest is affected, and concomitantly, a greater burden will be placed upon the state to justify such classification. Moreover, courts will closely scrutinize a classification where the interests of those who are unable to effectively protect their interests are at stake.¹³³

There is no question that the equal protection clause applies to eligibility for public educational programs. "Such an opportunity, where the state has undertaken to provide it, is a right which must be made available to all on equal terms."¹³⁴ But is education such a fundamental interest that the strict standard of review in determining whether a classification for excluding children from the public school system is reasonable should be applied? Again, *Brown* is quite forthright in its position on the fundamental nature of the availability of an education:

Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society.¹³⁵

More recently, the California Supreme Court has stated that "education is the lifeline of both the individual and society."¹³⁶ And the matter is perhaps most

131 *Levy v. Louisiana*, 391 U.S. 68 (1968); see also *Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955); *Morey v. Doud*, 354 U.S. 457, 465-66 (1957); *Ferguson v. Skrupa*, 372 U.S. 726, 732 (1963).

132 *Harper v. Virginia Bd. of Elections*, 383 U.S. 663, 670 (1966); see also *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969).

133 *United States v. Carolene Products Co.*, 304 U.S. 144 (1938).

134 *Brown v. Board of Education*, 347 U.S. 483, 493 (1954).

135 *Id.*

136 *Serrano v. Priest*, 96 Cal. Rptr. 601, 616, 487 P.2d 1241, 1256 (1971).

aptly summarized by the district court in *VanDusartz v. Hatfield*:¹³⁷

Where the onus of a legislative classification falls upon an interest which is classified as "fundamental," the State bears the burden of demonstrating a compelling interest of its own which is served by the challenged legislation and which cannot be satisfied by any other convenient legal structure. That approach fits this case because the interest at stake is education. The *Serrano* opinion . . . has correctly inferred from relevant expressions of the United States Supreme Court and from the nature of education itself that this interest is truly fundamental in the constitutional sense.¹³⁸

2. IS EXCLUSION OF THE RETARDED REASONABLY CONSISTENT WITH THE OBJECTIVES OF EDUCATION?

If it is accepted that education is a fundamental interest, with the correlative requirement that the state must bear a substantial burden when it undertakes to exclude a particular group from the public school system, is there anything in the nature of the educational process which would justify a state in excluding the mentally retarded from its system? The courts have recognized that education is the principal instrument for the child "in helping him to adjust normally to his environment" and that "it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education";¹³⁹ that "education has become the *sine qua non* of useful existence";¹⁴⁰ and that it has "a significant role to play in shaping the student's emotional and psychological make-up."¹⁴¹

Accordingly, is there any rational basis for not extending the benefits of education to a retarded child? This question must necessarily be answered in the negative because the retarded child has all the more need for an educational opportunity. The Maryland Governor's Commission eloquently stated the basis for encompassing the retarded child within the public educational school system:

The basis for special education is founded in the belief that every child is equally entitled to full recognition of his rights to an educational opportunity consistent with his capacity to learn. . . .

. . . The basic philosophical objectives must surely be the same for all children: each individual should have the opportunity to become all that he is capable of being, regardless of his economic level, sex, color, religion, national origin, geographic location, or handicapping condition. *His education should equip him with the tools needed in life so that he can be of greater value to himself and his community.* . . .

. . . Each child should be seen as a unique individual and should be dealt with in terms of his own needs. The handicapped child has all the basic needs of the non-handicapped child, as well as some exceptional needs which must be served. He should have the benefit of an educational program designed to suit his capacity and to develop him to the fullest possible extent of his potential.¹⁴²

137 334 F. Supp. 870 (D. Minn. 1971).

138 *Id.* at 874-75.

139 *Brown v. Board of Education*, 347 U.S. 483, 493 (1954).

140 *Manjares v. Newton*, 49 Cal. Rptr. 805, 812, 411 P.2d 901, 908 (1966).

141 *Hobson v. Hansen*, 269 F. Supp. 401, 483 (D. D.C. 1967).

142 1966 MARYLAND REPORT, *supra* note 121, at 4-6.

More recently, the author of the brief in the *Pennsylvania* litigation has stated:

These purposes pertain with equal, even greater, force to retarded citizens. Absent a structured, formal opportunity to secure an education, the purpose will not likely be realized by retarded citizens at all; for them, development and learning is unlikely to come informally or by happenstance, as it does for so many others. And the consequences are considerably more severe for retarded citizens. Absent education the retarded citizen will be unable to provide for himself and may even be incapable of self-care and hence in jeopardy of institutionalization, loss of liberty, and even loss of life.¹⁴³

But what of the arguments that particular groups of retarded children cannot learn, that they cannot take advantage of the benefits of an education, and thus should be excluded from the public school system. It is well known that many of the public school systems which do have a special education program for the mentally retarded nevertheless have provisions which exclude from the programs those who cannot "benefit" therefrom.¹⁴⁴ Such a proposition flies in the face of current professional opinion. These "pessimistic views, which have been so widely, and for so long, entertained regarding the ineducability of the mental defective, are unwarranted."¹⁴⁵ The Council for Exceptional Children now takes the position:

There is no dividing line which excludes some children and includes others in educational programs. Mentally retarded children of yesteryear who were excluded because they were "unteachable" have recently become "educable" or "trainable."¹⁴⁶

And the National Association for Retarded Children adheres to the following position:

Public School education must be provided for all mentally retarded persons, including the severely and profoundly retarded. There should be no dividing line which excludes children from public education services. If current

143 Plaintiffs' Memorandum in Support of Their Motion to Convene a Three Judge Court at 4, *Pennsylvania Ass'n. Retard. Children v. Commonwealth of Pa.* (E.D. Pa. 1971). At the risk of using a somewhat strained analogy, one of the most recent Supreme Court decisions in the equal protection area also supports the argument that the mentally retarded should have equal access to the public school system. In *Eisenstadt v. Baird*, 92 S. Ct. 1029, 1038 (1972) the Court held that "whatever the rights of the individual to access to contraceptives may be, the rights must be the same for the married and unmarried alike." If the equal protection clause mandates that unmarried persons shall have the same access to contraceptives as married persons, then surely the mentally retarded should have the same access to public education as normal children have.

144 1966 MARYLAND REPORT, *supra* note 121, at 3. See also MR 69, *supra* note 116, at 17-18, where the authors stated:

A few states now require education programs for all children of school attendance age. Most, however, effectively exclude many handicapped children by offering few or no programs for them, while tens of thousands of retarded children, too mildly affected to be assigned to traditional classes for the educable or trainable retarded, stumble as best they can through regular classes. These drop out of school as soon as they can, often to fall into the marginal-subsistence spawning grounds of chronic welfare, health and social problems.

145 YATES, *BEHAVIOR THERAPY* 324 (1970); see also BAUMEISTER, *supra* note 2, at 181.

146 Editorial, 37 *JOURNAL OF EXCEPTIONAL CHILDREN*, 422, 429 (1971).

educative technologies and facilities are inappropriate for the education of some retarded persons, then these existing educational regimes should be modified.¹⁴⁷

Judicial recognition that *all children* are educable and that *all retarded children*, even those severely and profoundly retarded, should have access to the benefits of the public school system, first appeared in *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*,¹⁴⁸ where the court, in its order, injunction and consent agreement, set forth the following:

Expert testimony in this action indicates that all mentally retarded persons are capable of benefiting from a program of education and training: that the greatest number of retarded persons, given such education and training, are capable of achieving self-sufficiency, and the remaining few, with such education and training, are capable of achieving some degree of self-care; that the earlier such education and training begins, the more thoroughly and the more efficiently a mentally retarded person will benefit from it; and, whether begun early or not, that a mentally retarded person can benefit at any point in his life and development from a program of education and training.

The Commonwealth of Pennsylvania has undertaken to provide a free public education to all of its children between the ages of six and twenty-one years, and, even more specifically, has undertaken to provide education and training for all its exceptional children.

Having undertaken to provide a free public education to all of its children, including its exceptional children, the Commonwealth of Pennsylvania may not deny any mentally retarded child access to a free public program of education and training.

It is the Commonwealth's obligation to place each mentally retarded child in a free, public program of education and training appropriate to the child's capacity, within the context of a presumption that, among the alternative programs of education and training required by statute to be available, placement in a regular public school class is preferable to placement in a special public school class and placement in a special public school class is preferable to placement in any other type of program of education and training.¹⁴⁹

Those who dispute the foregoing positions are not really arguing that a retarded child cannot benefit from an educational experience, but are in effect taking the position that the cost of providing such an experience is not balanced by the benefits that accrue to the retarded child. Thus, for the sake of economy, they would exclude certain retarded children from the benefits of the public educational system.

Such a position cannot be justified legally, economically, or morally. From a legal standpoint, constitutional rights may not be abridged because implementa-

147 Policy Statement on the Education of Mentally Retarded Children, adopted April 1971, p. 2, NARC.

148 334 F. Supp. 1257 (E.D. Pa. 1971).

149 *Id.* at 1259-60; *see also* *Mills v. Board of Education of District of Columbia*, Civil No. 1939-71 (D.C. D.C. Aug. 1, 1972).

tion requires expenditure of public funds.¹⁵⁰ From an economic standpoint, the cost of education is far less than the cost of institutionalization which may be the result if education is slighted.¹⁵¹ Finally, from a moral standpoint, the response is a simple one: preservation of human dignity simply cannot be measured in terms of dollars and cents. As President John F. Kennedy stated in 1961: "[T]he true measure of a society can be seen in what it does for its members who are least endowed."¹⁵²

VI. Conclusion

Of the three topics considered in this article, guardianship, institutionalization, and education, the prospects for the retarded appear the brightest in the area of education. Not only is there a federal constitutional basis for arguing that the retarded are entitled to a public education, but also the same result is mandated by many of the state constitutions, which require the establishment of a public educational system that is open to all.¹⁵³ Moreover, the requirement of upgrading the quality of habilitation in state institutions, and the concomitant cost spiral resulting therefrom, will create tremendous pressures to provide services to the retarded outside the traditional, huge warehouse-type institution. Finally, the number of special educational programs and the awareness of the long-run financial benefits flowing from such programs has been increasing.

But even in the area of education, one landmark decision, such as the *Pennsylvania* decision, is no absolute guarantee that the retarded throughout the country will generally have made available to them their now-defined constitutional rights. Legislatures and state and local boards of education across the country will need to be educated—and possibly encouraged—with or without further use of the judicial process. Judges Broderick, Adams, and Masterson have shown forthrightness and sensitivity in their handling of the *Pennsylvania* litigation; other courts may well need to step into the breach in other jurisdictions. These jurists, and Judge Johnson of Alabama, have opened the courtroom door to the advocates of the retarded and have awakened the American public to the plight of the retarded.¹⁵⁴

While it would be quixotic to expect the judiciary to right all wrongs, the

150 See text following note 94 *supra*; see also the Court's statement in *Shapiro v. Thompson*, 394 U.S. 618, 633 (1969) that a state "could not, for example, reduce expenditures for education by barring indigent children from its schools."

151 See text accompanying and following note 114 *supra*.

152 Haggerty, Kane, & Udall, *An Essay on the Legal Rights of the Mentally Retarded*, *supra* note 1, at 61.

153 See, e.g., IND. CONST., art 8, § 1, which provides in part that the Legislature shall provide "[f]or a General and Uniform System of Common Schools, wherein tuition shall be without charge, and equally open to all."

Similarly, WIS. CONST., art. 10, § 3, provides that the Legislature shall establish district schools and that "such schools shall be free and without charge for tuition to all children between the ages of 4 and 20 years." It is of interest that in an early case, *State v. Board of Education* 169 Wis. 236, 172 N.W. 153 (1919) the Wisconsin courts permitted exclusion of a mentally retarded child on the basis that "its presence therein is harmful to the best interest of the school." However, in 1967, Wisconsin Attorney General La Follette reasoned that if a retarded child is excluded from school, the obligation to provide him with a free public education remains and some other means must be provided.

154 N.Y. Times, Oct. 9, 1971, at 23, col. 2; *id.*, Mar. 26, 1972, at 14, col. 5.

fact of the matter is that there will be increasingly frequent resort to the judiciary to define and secure the retarded's legal rights. Matters, some of which at one time were thought to be essentially within the province of the executive or legislative spheres, have now been phrased so as to raise justiciable issues. In many instances, the advocates of the retarded have become disenchanted with the compromising, delay, and lack of response they have discovered in working with the executive and legislative branches of government.¹⁵⁵

On the other hand, the judiciary has no such alternatives available to it. Accordingly, the advocates of the retarded are looking to the judiciary for forthright recognition of the legal rights of the retarded. As Chief Justice Warren has stated:

The Judge is not justified in parceling out a portion of the rights established by a statute or the Constitution. It is his duty to afford plenary relief in accordance with the law as written. To do less or more would be a distortion of the judicial process and violation of his oath. The judicial process, therefore, might well be described as "the process of principle" as distinguished from "the art of the possible."¹⁵⁶

As litigation in this area continues to unfold, let us hope the judiciary continues true to Justice Warren's charge.

APPENDIX*

Minimum Constitutional Standards for Adequate Habilitation of the Mentally Retarded

I. *Definitions*

The terms used herein below are defined as follows:

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

¹⁵⁵ The public so often fails to comprehend the distinction between the political process and the judicial process. In the words of former Chief Justice Earl Warren:

[T]hey are so accustomed to witnessing trading, compromising, and postponing in the political process that unthinkingly they attribute the same characteristics to the judicial process. They fail to recognize that whenever the Congress discerns some defect in our society, within its constitutional limits, it can reach out and bring the matter before it for solution. If it cannot achieve consensus on the basis of a complete solution, it may compromise for a half or quarter loaf or even postpone its definitive action to a later day. That is why the political process is said to be "The art of the possible."

Warren, *Notre Dame Law School Civil Rights Lectures*, 48 NOTRE DAME LAWYER 14, 16 (1972).

¹⁵⁶ *Id.* at 17.

* *Wyatt v. Stickney*, Civil No. 3195-N (M.D. Ala., Apr. 13, 1972).

c. "Qualified Mental Retardation Professional"—

(1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded; (2) a physician licensed to practice in the State of Alabama, with specialized training or one year's experience in treating the mentally retarded; (3) an educator with a master's degree in special education from an accredited program; (4) a social worker with a master's degree from an accredited program and with specialized training or one year's experience in working with the mentally retarded; (5) a physical, vocational or occupational therapist licensed to practice in the State of Alabama who is a graduate of an accredited program in physical, vocational or occupational therapy, with specialized training or one year's experience in treating the mentally retarded; (6) a registered nurse with specialized training or one year of experience treating the mentally retarded under the supervision of a Qualified Mental Retardation Professional.

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

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

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

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

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

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

II. *Adequate Habilitation of Residents*

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.
2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.
3.
 - a. No person shall be admitted to the institution unless a prior determination shall have been made¹ that residence in the institution is the least restrictive habilitation setting feasible for that person.
 - b. No mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person.
 - c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.
4. No borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.
5. Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps.

¹ See Standard 7, *infra*.

- a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, *supra*, and the other standards proposed herein.
- b. School-age residents shall be provided a full and suitable educational program. Such educational programs shall meet the following minimum standards:

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

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

III. *Individualized Habilitation Plans*

7. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialists to determine if admission is appropriate.
 - a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.
 - b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.
8. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.
9. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible

² As is reflected in Standard 4, *supra*, it is contemplated that no mildly retarded persons be residents of the institution. However, until those mildly retarded who are presently residents are removed to more suitable locations and/or facilities, some provision must be made for their educational program.

but no later than 14 days after the resident's admission to the institution. An interim program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, *supra*, shall commence promptly upon the resident's admission. Each individualized habilitation plan shall contain:

- a. a statement of the nature of the specific limitations and specific needs of the resident;
 - b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;
 - c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;
 - d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;
 - e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;
 - f. criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected date for discharge.
10. As part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.
 11. In the interests of continuity of care, one Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is released when appropriate to a less restrictive habilitation setting.
 12. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident

shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an interdisciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care workers as are directly involved in his habilitation and care.

13. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.³ In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation for mental retardation with his medical treatment.
14. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals and to the resident care workers who are directly involved with the particular resident. All information contained in a resident's records shall be considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:
 - a. Identification data, including the resident's legal status;
 - b. The resident's history, including but not limited to: (1) family data, educational background, and employment record; (2) prior medical history, both physical and mental, including prior institutionalization;
 - c. The resident's grievances if any;
 - d. An inventory of the resident's life skills;
 - e. A record of each physical examination which describes the results of the examination;
 - f. A copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;
 - g. The findings made in periodic reviews of the habilitation plan (see Standard 12, *supra*), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary;
 - h. A copy of the post-institutionalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;
 - i. A medication history and status, pursuant to Standard 22, *infra*;
 - j. A summary of each significant contact by a Qualified Mental Retardation Professional with the resident;
 - k. A summary of the resident's response to his program, prepared by a Qualified Mental Retardation Professional involved in the resident's habilita-

³ Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlow.

tion and recorded at least monthly. Such response, wherever possible, shall be scientifically documented. l. A monthly summary of the extent and nature of the resident's work activities described in the Standard 33(b), *infra* and the effect of such activity upon the resident's progress along the habilitation plan; m. A signed order by a Qualified Mental Retardation Professional for any physical restraints, as provided in Standard 26(a)(1), *infra*; n. A description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of resident mistreatment, as required by Standard 28, *infra*; o. A summary of family visits and contacts; p. A summary of attendance and leaves from the institution; q. A record of any seizures, illnesses, treatments thereof, and immunizations.

IV. *Humane Physical and Psychological Environment*

15. Residents shall have a right to dignity, privacy and humane care.
16. Residents shall lose none of the rights enjoyed by citizens of Alabama and of the United States solely by reason of their admission or commitment to the institution, except as expressly determined by an appropriate court.
17. No person shall be presumed mentally incompetent solely by reason of his admission or commitment to the institution.
18. The opportunity for religious worship shall be accorded to each resident who desires such worship. Provisions for religious worship shall be made available to all residents on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.
19. Residents shall have the same rights to telephone communication as patients at Alabama public hospitals, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued. Residents shall have an unrestricted right to visitation, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued.

20. Residents shall be entitled to send and receive sealed mail. Moreover, it shall be the duty of the institution to facilitate the exercise of this right by furnishing the necessary materials and assistance.
21. The institution shall provide, under appropriate supervision, suitable opportunities for the resident's interaction with members of the opposite sex, except where a Qualified Mental Retardation Professional responsible for the formulation of a particular resident's habilitation plan writes an order to the contrary and explains the reasons therefor.

22. *Medication:*

a. No medication shall be administered unless at the written order of a physician. b. Notation of each individual's medication shall be kept in his medical records (Standard 14(i) *supra*). At least weekly the attending physician shall review the drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. c. Residents shall have a right to be free from unnecessary or excessive medication. The resident's records shall state the effects of psychoactive medication on the resident. When dosages of such are changed or other psychoactive medications are prescribed, a notation shall be made in the resident's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur. d. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation program, or in quantities that interfere with the resident's habilitation program. e. Pharmacy services at the institution shall be directed by a professionally competent pharmacist licensed to practice in the State of Alabama. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education. Appropriate officials of the institution, at their option, may hire such a pharmacist or pharmacists fulltime or, in lieu thereof, contract with outside pharmacists. f. Whether employed fulltime or on a contract basis, the pharmacist shall perform duties which include but are not limited to the following: (1) Receiving the original, or direct copy, of the physician's drug treatment order; (2) Reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications and advising the physician of any recommended changes, with reasons and with an alternate drug regimen; (3) Maintaining for each resident an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills; (4) Participating, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs. g. Only appropriately trained staff shall be allowed to administer drugs.

23. Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and direct professional supervision as a technique in behavior-shaping programs.
24. Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.
25. Electric shock devices shall be considered a research technique for the purpose of these standards. Such devices shall only be used in extraordinary circumstances to prevent self-mutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed. The use of such devices shall be subject to the conditions prescribed in Standard 24, *supra*, and Standard 29, *infra*, and shall be used only under the direct and specific order of the superintendent.
26. Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to prevent injury to others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose.
 - a. Only Qualified Mental Retardation Professionals may authorize the use of restraints. (1) Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours. (2) A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept. (3) Mechanical restraints shall be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort. (4) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed. (5) Daily reports shall be made to the superintendent by those Qualified Mental Retardation Professionals ordering the use of restraints, summarizing all such uses of restraint, the types used, the duration, and the reasons therefor.
 - b. The institution shall cause a written statement of this policy to be posted in each living unit and circulated to all staff members.

27. Corporal punishment shall not be permitted.
28. The institution shall prohibit mistreatment, neglect or abuse in any form of any resident.
 - a. Alleged violations shall be reported immediately to the superintendent and there shall be a written record that: (1) Each alleged violation has been thoroughly investigated and findings stated; (2) The results of such investigation are reported to the superintendent and to the commissioner within 24 hours of the report of the incident. Such reports shall also be made to the institution's Human Rights Committee monthly and to the Alabama Board of Mental Health at its next scheduled public meeting.
 - b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.
29. Residents shall have a right not to be subjected to experimental research without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the institution's Human Rights Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.
30. Residents shall have a right not to be subjected to any unusual or hazardous treatment procedures without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and legal counsel. Such proposed procedures shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought.
31. Residents shall have a right to regular physical exercise several times a week. It shall be the duty of the institution to provide both indoor and outdoor facilities and equipment for such exercise.
32. Residents shall have a right to be outdoors daily in the absence of contrary medical considerations.

33. The following rules shall govern resident labor:

a. *Institution Maintenance*

(1) No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966. (2) No resident shall be involved in the care (feeding, clothing, bathing), training, or supervision of other residents unless he: (a) has volunteered; (b) has been specifically trained in the necessary skills; (c) has the humane judgment required for such activities; (d) is adequately supervised; and (e) is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

b. *Training Tasks and Labor*

(1) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is: (a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation; (b) supervised by a staff member to oversee the habilitation aspects of the activity. (2) Residents may voluntarily engage in habilitative labor at nonprogram hours for which the institution would otherwise have to pay an employee, provided the specific labor or any change in labor is: (a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation; (b) Supervised by a staff member to oversee the habilitation aspects of the activity; and (c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

c. *Personal Housekeeping* Residents may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

d. Payment to residents pursuant to this paragraph shall not be applied to the costs of institutionalization.

- e. Staffing shall be sufficient so that the institution is not dependent upon the use of residents or volunteers for the care, maintenance or habilitation of other residents or for income-producing services. The institution shall formulate a written policy to protect the residents from exploitation when they are engaged in productive work.
34. A nourishing, well-balanced diet shall be provided each resident.
- a. The diet for residents shall provide at a minimum the Recommended Daily Dietary Allowance as developed by the National Academy of Sciences. Menus shall be satisfying and shall provide the Recommended Daily Dietary Allowances. In developing such menus, the institution shall utilize the Moderate Cost Food Plan of the United States Department of Agriculture. The institution shall not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Moderate Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of residents, discounted for any savings which might result from institutional procurement of such food. b. Provisions shall be made for special therapeutic diets and for substitutes at the request of the resident, or his guardian or next of kin, in accordance with the religious requirements of any resident's faith. c. Denial of a nutritionally adequate diet shall not be used as punishment. d. Residents, except for the non-mobile, shall eat or be fed in dining rooms.
35. Each resident shall have an adequate allowance of neat, clean, suitably fitting and seasonable clothing.
- a. Each resident shall have his own clothing, which is properly and inconspicuously marked with his name, and he shall be kept dressed in this clothing. The institution has an obligation to supply an adequate allowance of clothing to any residents who do not have suitable clothing of their own. Residents shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the resident's throughout his stay in the institution. b. Clothing both in amount and type shall make it possible for residents to go out of doors in inclement weather, to go for trips or visits appropriately dressed, and to make a normal appearance in the community. c. Non-ambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated in written medical orders. d. Washable clothing shall be designed for multiple handicapped residents being trained in self-help skills, in accordance with individual needs. e. Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training. f. A current inventory shall be kept of each resident's personal and clothing items.

g. The institution shall make provision for the adequate and regular laundering of the residents' clothing.

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

37. a. Each resident shall be assisted in learning normal grooming practices with individual toilet articles, including soap and toothpaste, that are available to each resident. b. Teeth shall be brushed daily with an effective dentifrice. Individual brushes shall be properly marked, used, and stored. c. Each resident shall have a shower or tub bath at least daily, unless medically contraindicated. d. Residents shall be regularly scheduled for hair cutting and styling, in an individualized manner, by trained personnel. e. For residents who require such assistance, cutting of toenails and fingernails shall be scheduled at regular intervals.

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

a. *Resident Unit* All ambulatory residents shall sleep in single rooms or in multi-resident rooms of no more than six persons. The number of nonambulatory residents in a multi-resident room shall not exceed ten persons. There shall be allocated a minimum of 80 square feet of floor space per resident in a multi-resident room. Screens or curtains shall be provided to ensure privacy. Single rooms shall have a minimum of 100 square feet of floor space. Each resident shall be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, and appropriate furniture such as a chair and a bedside table, unless contraindicated by a Qualified Mental Retardation Professional who shall state the reason for any such restriction. b. *Toilets and Lavatories* There shall be one toilet and one lavatory for each six residents. A lavatory shall be provided with each toilet facility. The toilets shall be installed in separate stalls for ambulatory residents, or in curtained areas for nonambulatory residents, to ensure privacy, shall be clean and free of odor, and shall be equipped with appropriate safety devices for the physically handicapped. Soap and towels and/or drying mechanisms shall be available in each lavatory. Toilet paper shall be available in each toilet facility. c. *Showers* There shall be one tub or shower for each eight residents. If a central bathing area is provided, each tub or shower shall be divided by curtains to ensure privacy. Showers and tubs shall be equipped with adequate safety accessories. d. *Day Room* The minimum day room area shall be 40 square feet per

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

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

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

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

i. *Physical Plant*

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

shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to it.

V. *Qualified Staff in Numbers Sufficient to Provide Adequate Habilitation*

- 39. Each Qualified Mental Retardation Professional and each physician shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama. a. All resident care workers who have not had prior clinical experience in a mental retardation institution shall have suitable orientation training. b. Staff members on all levels shall have suitable, regularly scheduled in-service training.
- 40. Each resident care worker shall be under the direct professional supervision of a Qualified Mental Retardation Professional.

41. *Staffing Ratios*

a. Qualified staff in numbers sufficient to administer adequate habilitation shall be provided. Such staffing shall include but not be limited to the following fulltime professional and special services. Qualified Mental Retardation Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Substantial changes in staff deployment may be made with the prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure would enhance the habilitation of the residents. Professional staff shall possess the qualifications of Qualified Mental Retardation Professionals as defined herein unless expressly stated otherwise.

	<i>Mild⁴</i>	<i>Mod- erate</i>	<i>Severe/ Profound</i>
b. <i>Unit</i>	60	60	60
(1) Psychologists	1:60	1:60	1:60
(2) Social Workers	1:60	1:60	1:60
(3) Special Educators (shall include an equal number of master's degree and bachelor's degree holders in special education)	1:15	1:10	1:30
(4) Vocational Therapists	1:60	1:60	-----

⁴ See n. 2, *supra*.

(5) Recreational Therapists (shall be master's degree graduates from an accredited program)	1:60	1:60	1:60
(6) Occupational Therapists	-----	-----	1:60
(7) Registered Nurses	1:60	1:60	1:12
(8) Resident Care Workers	1:2.5	1:1.25	1:1

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

Physicians	1:200
Physical Therapists	1:100
Speech & Hearing Therapists	1:100
Dentists ⁵	1:200
Social Workers (shall be principally involved in the placement of residents in the community and shall include bachelor's degree graduates from an accredited program in social work)	1:80
Chaplains ⁶	1:200

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

VI. *Miscellaneous*

42. The guardian or next of kin of each resident shall promptly, upon resident's admission, receive a written copy of all the above standards for adequate habilitation. Each resident, if the resident is able to comprehend, shall promptly upon his admission be orally informed in clear language of the above standards and, where appropriate, be provided with a written copy.
43. The superintendent shall report in writing to the next of kin or guardian of the resident at least every six months on the resident's educational, vocational and living skills progress and medical condition. Such report

5 Defendants may, in lieu of employing fulltime dentists, contract outside the institution for dental care. In this event the dental services provided the residents must include (a) complete dental examinations and appropriate corrective dental work for each resident each six months and (b) a dentist on call 24 hours per day for emergency work.

6 Defendants may, in lieu of employing fulltime chaplains, recruit, upon the ratio shown above, interfaith volunteer chaplains.

shall also state any appropriate habilitation program which has not been afforded to the resident because of inadequate habilitation resources.

44. a. No resident shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without prior certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures. b. No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional convenience.
45. No resident shall have any of his organs removed for the purpose of transplantation without compliance with the procedures set forth in Standard 30, *supra*, and after a court hearing on such transplantation in which the resident is represented by a guardian *ad litem*. This standard shall apply to any other surgical procedure which is undertaken for reasons other than therapeutic benefit to the resident.
46. Within 90 days of the date of this order, each resident of the institution shall be evaluated as to his mental, emotional, social, and physical condition. Such evaluation or reevaluation shall be conducted by an interdisciplinary team of Qualified Mental Retardation Professionals who shall use professionally recognized tests and examination procedures. Each resident's guardian, next of kin or legal representative shall be contacted and his readiness to make provisions for the resident's care in the community shall be ascertained. Each resident shall be returned to his family, if adequately habilitated, or assigned to the least restrictive habilitation setting.
47. Each resident discharged to the community shall have a program of transitional habilitation assistance.
48. The institution shall continue to suspend any new admissions of residents until all of the above standards of adequate habilitation have been met.
49. No person shall be admitted to any publicly supported residential institution caring for mentally retarded persons unless such institution meets the above standards.