Rights into Action: Protecting Human Rights of the Mentally Handicapped

Stanley S. Herr

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RIGHTS INTO ACTION: PROTECTING HUMAN RIGHTS OF THE MENTALLY HANDICAPPED

Stanley S. Herr

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RIGHTS INTO ACTION: PROTECTING HUMAN RIGHTS OF THE MENTALLY HANDICAPPED†

Stanley S. Herr*

The legislative imperfections in the definition of human rights and freedoms and the lack of mechanism for implementation do not constitute a reason for denying their existence and the need for their legal protection.¹

On December 20, 1971, the United Nations General Assembly, voting unanimously, adopted the Declaration on the Rights of Mentally Retarded Persons.² Member nations thereby pledged themselves to promote the integration of mentally disabled persons “as far as possible in normal life.”³ The declaration provides a common frame of reference for protecting the rights of a long devalued minority. It also embodies an international consensus on

† © Copyright 1977 by Stanley S. Herr. This article is drawn from a survey report on the rights of the mentally retarded in Great Britain, Sweden, Denmark, and the Netherlands. The research was undertaken with the support of the Rosemary F. Dybwad International Award of the National Association for Retarded Citizens and with the cooperation of the International League of Societies for the Mentally Handicapped (ILSMH). The author acknowledges with sincerest gratitude the aid and counsel of the many devoted friends of the mentally handicapped interviewed in the course of this study. In particular, special appreciation is due to those reviewing drafts and organizing visits in the surveyed nations: Ann Shearer and James Elliot of England; Dr. Karl Grunewald, Allen Everitt, and Dr. Richard Sterner of Sweden; Jan Meiresonne of the Netherlands; John Møller and N.E. Bank-Mikkelsen of Denmark; Dr. Renee Portray and Dr. Elizabeth M. Boggs of the ILSMH; and S.G. Mentser and Kathryn Moss. To Dr. Rosemary F. Dybwad and Professor Gunnar Dybwad of Brandeis University, pioneers in the international human rights movement for the disabled, this article is dedicated.


standards by which a society's progress and deficiencies regarding these rights can be measured.

Recent surveys confirm that no country, not even the most industrialized or socially progressive, has realized these rights fully. Sometimes grave deficiencies are hidden under a false assumption that, because many are served, all are treated justly. Pledges of legal and human rights for the disabled, without more, are illusory. New institutional arrangements are needed if those rights are to be taken seriously.

I. AN IMPERILED SILENT MINORITY

Rights are generally exercised by the assertive. Legal systems do not often bestir themselves for those too inarticulate or infirm to protest fundamental deprivations. One exception has been the use of law to protect the mentally incompetent from neglect, exploitation, or degrading treatment. But civil commitment or guardianship too often carries a fearful cost in human


5. In recognition of this fact, the ILSMH formed the Task Group on Implementation of Rights to assist its member societies in taking remedial action. Chaired by Dr. Elizabeth Boggs, its other members are Paulino Azua (Spain), Ann Belpaire (Belgium), Yvonne Posternak (Switzerland), Isaac M. Shemer (Israel), and the author of this article. See generally Task Group on Implementation of Rights, Some Analytical Guidelines for National Societies (1976) (available from the National Association for Retarded Citizens, 1522 K Street, N.W., Washington, D.C.).


We must not fail to distinguish, moreover, between the condition of a Donaldson—intelligent and in command of the complexities of his incarceration and assisted by two such able champions as Birnbaum and Ennis—and the condition of most people who, because of illness or for economic or intellectual reasons cannot help themselves. Those without voices they can raise, those submerged by what has engulfed them—it is those people we must attend.


dignity and self-respect. That cost can be measured in terms of loss of liberty, property, reputation, and even life. Mindful of those deprivations, the friends of the mentally handicapped seek services and protections free of stigmatizing labels and unwarranted paternalism. Their campaign aims to place access to services on the footing of rights rather than privileges. It opposes discrimination based on stereotypes and demands fair treatment based on an individual's specific abilities and disabilities.

Concern over these human rights is relatively new. Until recent years, the public and the legal profession registered scant interest in the "rightlessness" of the disabled. This was especially true of the diminished legal rights and status of a wide array of persons loosely referred to as "mentally retarded"


11. This campaign for the protection of the human rights of mentally handicapped persons has realized some success in the United States. See, e.g., Rehabilitation Act of 1973, 29 U.S.C. §§ 793, 794 (Supp. V 1975); N.Y. MENTAL HYG. LAW § 15.01 (McKinney 1972 Supp.) (protection of patient's rights); President's Comm. on Mental Retardation, Mental Retardation: Century of Decision 58-67, 89-98 (1976). The Lanterman Developmental Disabilities Services Act, (1976 Cal. Legis. Serv. ch. 1364), provides to developmentally disabled persons a right to treatment and habilitation services and to publicly supported education, regardless of degree of handicap. The Act also guarantees freedom from harm, including unnecessary physical restraint, isolation, or excessive medication, and opportunities for participation in community activities. Section 3800(2) states:

Persons with developmental disabilities have the same legal rights and responsibilities guaranteed all other individuals by the Federal Constitution and laws and the Constitution and laws of the State of California. No otherwise qualified person by reason of having a developmental disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, which receives public funds.
or "mentally handicapped." Writing in 1960, Professor Gunnar Dybwad, a pioneer in this field, referred to a societal "temptation" to deal summarily with the retarded by divesting them of personal rights. In 1968, the International League of Societies for the Mentally Handicapped (ILSMH), calling attention to those divestitures, adopted the Declaration of General and Special Rights of Mentally Retarded Persons. Three years later, the United Nations based its Declaration on the Rights of Mentally Retarded Persons on this text. Since then, activists have transformed those civil rights issues from an esoteric matter to a major public concern. In the courts,

12. The terms "mentally retarded" and "mentally handicapped" will be used interchangeably in this article. Usage of the latter term is more prevalent in Great Britain, while the term "mentally retarded" seems to have a wider currency. A broad range of disabilities have been encompassed in either concept, as exemplified by the American Association on Mental Deficiency's definition of mental retardation as referring "to significantly sub-average intellectual functioning, existing concurrently with deficits in adaptive behavior, and generally manifest during the developmental period." American Ass'n on Mental Deficiency, Manual on Classification and Terminology in Mental Retardation 11 (H. Grossman ed. 1973). Developmental disabilities, the category used in federal legislation, is even broader. It includes persons afflicted with mental retardation, cerebral palsy, epilepsy, and other related disabilities. Developmental Disabilities Assistance and Bill of Rights Act of 1975, 42 U.S.C.A. § 6001 (Cum. Supp. 1976). Accordingly, a "mentally retarded person," not to mention a "developmentally disabled person," may possess a considerable repertoire of abilities, and may have specific disabilities ranging from minimal to profound.

13. G. Dybwad, Trends and Issues in Mental Retardation (Mar. 30, 1960) (working paper prepared for the 1960 White House Conference on Children and Youth), in G. Dybwad, Challenges in Mental Retardation 211 (1964). More recently, Professor Dybwad observed: "Earlier we had these philosophical declarations. But administrative authority was seldom challenged, and if challenged, could only be challenged to another bureaucratic office. The trend is now toward judicial processes: to limiting executive authority by judicial authority." Interview with Professor Gunnar Dybwad in Oxford, England (May 11, 1975).


15. See R. Sterner, supra note 4, at iii.

16. In surveying international activity regarding these issues in 1973, Dr. Rosemary F. Dybwad wrote:

If a prediction for the 1970's can be made today, a likely forecast is that it will be the decade of translating [the 1971 U.N. Declaration] into action. In this process, normalizing the environment and day-to-day life of the mentally retarded individual and safeguarding his personal dignity and integrity will be key factors.


17. See, e.g., New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); "During the three-year course of this litigation, the fate of the mentally impaired members of our society has passed from an arcane concern to a major issue both of constitutional rights and social policy." Id. at 716.
legislatures, professional journals the rights of the intellectually
deficient have become subjects of lively reevaluation. The United States,
for example, now has a “Bill of Rights Act” which requires each state by
October 1977 to establish an independent “system to protect and advocate
the rights of persons with developmental disabilities.” The time is right to
consider the experiences of other industrialized nations in securing similar
rights.

This article examines some legal protections for retarded persons in four
Western European countries. Rather than a compilation of facts on implement-
ing national programs, its focus is on individual rights. The article

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Individuals); Swedish Law on Guardianship and Trusteeship (1975), discussed infra at pp. 236-37; note 11 supra.
19. See, e.g., The Lancet, Aug. 23, 1975, at 353:
The rights of the mentally handicapped as individuals have been overlooked
for too long. The realization that some part of their handicap may be avoid-
able should make us re-examine every aspect of their care, and try in every
way to extend to them all the capacities for individual freedom that the more
fortunate take for granted. The awful implications of any erosion of this prin-
ciple are only too clear.

See also American Association on Mental Deficiency, Rights of Mentally Retarded Per-

§ 6012 (Cum. Supp. 1976). This system must by statute have the authority to “pursue
legal, administrative, and other appropriate remedies” of developmentally disabled per-
sons receiving treatment, services, or habilitation within the state, and must “be independent
of any State agency” or other provider of services. For a detailed analysis of these
provisions and existing American models for carrying out their statutory functions, see S.
Herr, Advocacy Under the Developmental Disabilities Act (1976) (U.S. Dep't
of HEW, Developmental Disabilities Office).

21. For information on the law in the United States regarding retarded persons, see
The Mentally Retarded Citizen and the Law, supra note 8; Herr, Civil Rights, Uncivil
Asylums, and the Retarded, 43 U. Cin. L. Rev. 679 (1974); Herr, Retarded Children
and the Law, 23 Syracuse L. Rev. 995-1035 (1972); note 7 supra. For a compara-
ison of English and American law, see Herr, The Right to Education, 32 New Soc'y
409 (1975).

22. The following is a list of surveys that discuss the implementation of national pro-
grams: Danish National Service for the Mentally Retarded, General Survey
and History of the Development of Service Systems in Denmark (1969); A. For-
rest, R. Ritson & A. Zealley, New Perspectives in Mental Handicap (1973) (Scot-
land); K. Gruenwald, The Mentally Retarded in Sweden (2 ed. 1975); K. Jones,
Opening the Door: A Study of New Policies for the Mentally Handicapped
(1975) (England); J. Meiresonne, Care for the Mentally Retarded in the Nether-
lands (1975); M. Stevens, The Educational Needs of Severely Subnormal Chil-
dren (1975) (England); E. Topliss, Provision for the Disabled (1975); (England);
R. Sterner, supra note 4.
Catholic University Law Review

stresses mechanisms which can come into play when basic rights of mentally retarded individuals are infringed. Three issues are selected for analysis: the retarded person's access to education, to humane residential care, and to independent reviewing authorities.

The survey countries—Denmark, Great Britain, the Netherlands, and Sweden—share a number of advantageous features. Each has adopted legislation embodying principles of normalization and integration for the mentally retarded, as well as a comprehensive network of social security and social welfare services. Each government subscribes to the European Convention on Human Rights, a charter of fundamental freedoms providing machinery for the enforcement of certain international guarantees. Recognition of public responsibility to aid the weak and disabled is widespread in these countries and their economic development is sufficient to demonstrate and sustain high standards of care and therapy. Yet, within the limited number of countries studied, there is great diversity in legal, administrative, and service delivery patterns.

Do the mentally retarded citizens of countries as progressive as these need international recognition of their rights? Unfortunately, legacies of the past, here as elsewhere, have left a residue of discrimination and social isolation. Gaining political as well as legal recognition of the disabled's entitlements to a share of general benefits has sometimes involved a political

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24. In the course of this study, the author also received reports of favorable legislative developments in Belgium, France, Norway, and Scotland.
25. Other countries, of course, share these features. See R. Sterner, supra note 4, at 47-55.
29. Indeed, as the President's Committee on Mental Retardation reports, many Americans are surprised to discover that countries such as these are "far in advance" of the United States in moving towards goals for the prevention and treatment of mental retardation. Century of Decision, supra note 11, at 100.
30. See Herr, Civil Rights, supra note 21, at 696-708.
and legal struggle.\textsuperscript{31} A vulnerable and insular minority has required special support and legislation to realize those entitlements.\textsuperscript{32} Today some mentally retarded persons remain needlessly segregated from normal patterns of living or unjustifiably excluded from civic and political participation.\textsuperscript{38} The application of international standards of conduct could mean a great difference for such individuals.

Unlike other minorities suffering discrimination, the retarded have had to rely on others to be their spokesmen and publicists.\textsuperscript{34} Against public ignorance, intolerance, or indifference, retarded persons find energetic and devoted friends—parents, professionals, and officials alike—who combat regressive attitudes and unfair policies. Voluntary associations for retarded citizens and the ILSMH have exposed the harms of discrimination and degrading treatment. They have insisted that retarded persons, whatever their differences in capacity and appearance, are equal before the law. This reliance on others, however, is reduced as some mentally handicapped persons are trained to express and advocate their own choices.\textsuperscript{35} Yet, as

\begin{enumerate}
\item \textsuperscript{31} "A century or less ago, when most people, even many in the learned professions, looked upon the retarded as hopelessly incapable, often dangerous, almost sub-human creatures, they were not often thought of as having legally enforceable rights." Allen, \textit{Legal Rights of the Mentally Retarded}, in \textit{Proceedings of the Fourth Congress of the Int'l League of Societies for the Mentally Handicapped, From Charity to Rights} 69-70 (1969).
\item \textsuperscript{32} As former President Ford observed, "only recently have we sought to assure the right of mentally retarded citizens to develop their full potential, to share in the bounty of our land and to receive equal justice under law." \textit{The Mentally Retarded Citizen and the Law}, \textit{supra} note 8, at iii.
\item \textsuperscript{33} On British conditions, see, e.g., \textit{Campaign for the Mentally Handicapped, Whose Children?} (1974); Kushlick, \textit{The Mentally Handicapped}, in \textit{Nuffield Hospitals Trust, Positions, Movements and Directions in Health Services Research} (1974) (documenting that mentally handicapped children in hospitals can, in the future, be cared for in the community); Gostin, \textit{The Right to Vote for Mental Patients, Community Care}, May 26, 1976, at 12-14 (estimating that 50,000 to 75,000 residents in hospitals for the mentally handicapped and mentally ill are disenfranchised solely by reason of having only a hospital as their residence).
\item \textsuperscript{34} In this respect, the cause of the mentally retarded differs from the general case where, in the words of a United Nation's report, the "nerve center of the struggle for human rights is to be found in the people themselves, in the ventures of ordinary men and women to establish their claim to a decent unmolested life in the face of despotism and bigotry, of ignorance and intolerance, of superstition and tyranny." United Nations Dept' of Social Affairs, \textit{The Impact of the Universal Declaration of Human Rights} 3 (rev. ed. 1953).
\item \textsuperscript{35} Dr. Richard Sterner, an officer of the Swedish Parents' Association (RFUB), and a tireless fighter for disabled people, has observed that in a few countries, particularly Sweden and the United States, "some mentally retarded persons have had the opportunity to speak out themselves for their rights . . . demanding more recognition and respect as human beings, more jobs and meaningful occupations, more participation in community life, more organized leisure time activities." R. Sterner, \textit{supra} note 4, at 3.
\end{enumerate}
Dr. Richard Sterner points out, "it is just in the nature of things that the mentally retarded, with less opportunity than others to stand up for their interests, have so far been more silent than almost any other suffering minority."  

II. INTERNATIONAL STANDARDS

Mentally retarded children and adults are within the ambit of a growing number of international declarations and standards. In the first instance, they share in the humanitarian principles set out in the Universal Declaration of Human Rights and the international covenants on human rights. As members of diverse groups who have historically suffered discrimination, they may also partake in such statements as the Declaration on the Rights of the Child and the Convention on the Political Rights of Women. Furthermore, the Declaration on Social Progress and Development, as well as the various standards of United Nations agencies, proclaim the necessity of protecting the rights and assuring the rehabilitation of the physically and mentally disadvantaged. With the 1971 Declaration on the Rights of Mentally Retarded Persons, the United Nations gave added visibility to the special concerns for, and universal consensus respecting the rights of the mentally retarded. In 1975, this international body amplified these rights by promulgating the Declaration on the Rights of Disabled Persons and by

36. Id. Of the mentally retarded American, it has been written: "Our national experience and practice has been to deny him the care and training he requires to live a full life, enjoy liberty and pursue happiness. He is unable to protect his own interests and has little access to the legislative or judicial ear." President's Comm. on Mental Retardation, Silent Minority iii (1974).


42. See, e.g., World Health Organization, Introductory Guidelines to Mental Health Legislation (draft), OMH/73.4, Geneva.

adopting resolutions on the prevention of disability and the rehabilitation of disabled persons.\textsuperscript{44}

These formulations of international standards have been marked by increasing specificity and firmness. They are the products of nearly a decade of consultations, reports, and genteel lobbying.\textsuperscript{45} The ILSMH and its successive officers and secretariats have played a pivotal role in these developments. In particular, the ILSMH was instrumental in the adoption and dissemination of the 1971 United Nations Declaration on the Rights of Mentally Retarded Persons.\textsuperscript{46} That declaration will be the touchstone for much of the analysis that follows.

The origins of the declaration may be traced to some early ILSMH symposia. In 1967, representatives of 14 national member societies met to sketch “an outline for a programme” on the rights of the mentally retarded.\textsuperscript{47} This Stockholm Symposium succeeded in drafting desirable, though tentative and incomplete, standards on social services and individual rights.\textsuperscript{48} It noted various methods of implementing these standards, such as appeals to the courts, to legislative bodies, and to public opinion, as well as parental participation on oversight boards and dialogue with public authorities and the treating professions.\textsuperscript{49} Its conclusions were seen not as a final product, but as a stimulant to detailed studies and refining work. That process was advanced the following year in Jerusalem at the ILSMH’s Fourth International Congress. This Congress proclaimed a Declaration of General and Special Rights of the Mentally Retarded, which consisted of seven articles and a charter of fundamental freedoms.\textsuperscript{50} With a few technical modifications, this Jerusalem text served as the basis for the 1971 United Nations declaration that was to follow.\textsuperscript{51}


\textsuperscript{45} See, e.g., Int’l League of Societies for the Mentally Handicapped, Expert’s Papers, Symposium on Legislative Aspects of Mental Retardation (June 17, 1967).

\textsuperscript{46} See R. Sterner, supra note 4, at 1. Founded in 1960, the ILSMH is composed of 42 national member societies and 43 other member societies from 63 countries. The League’s object is to secure the “provision of efficient remedial, residential, educational, training, employment and welfare services for the mentally handicapped.” Towards that end, it promotes the interchange of information and workers in this field, and the “comparative study of legislation in the member countries and beyond concerning the mentally handicapped.” I.L.S.M.H. BROCHURE (1973) (on file with the Catholic University Law Review).

\textsuperscript{47} This meeting led to the publication of an official outline. See Int’l League of Societies for the Mentally Handicapped, Legislative Aspects of Mental Retardation (1967).

\textsuperscript{48} Id. at 8-11, 13-18.

\textsuperscript{49} Id. at 13.

\textsuperscript{50} See note 14 supra.

\textsuperscript{51} For example, the 1971 U.N. Declaration refers to a “right to perform productive
The General Assembly's 1971 declaration is a combination of broad affirmations of rights and ambiguous qualifications. Without defining mental retardation or the mentally retarded person, it declares that the latter has, "to the maximum degree of feasibility, the same rights as other persons." In successive articles, the declaration specifies the mentally retarded's basic rights to health and educational services, employment and income security, home and community life, guardianship (if required), due process of law and protection from abuse and degrading treatment, and proper legal safeguards against an improper or unwarranted restriction of rights. The thrust of the 1971 declaration is as unassailable as it is unmistakable—on grounds of retardation alone, no person is to be denied the fundamental rights which his fellow citizens of similar age enjoy.

The 1975 Declaration on the Rights of Disabled Persons builds upon the 1971 declaration, extending and clarifying its basic concepts. It encompassed work," rather than a "right to productive work." It does delete a valuable provision of the ILSMH Declaration (art. 5) which prohibits direct service providers from also acting as guardians for retarded individuals in their care.


53. 1971 U.N. Declaration, supra note 2, art. I.

54. Id. art. II guarantees to a retarded person "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."

55. Id. art. III provides that every retarded person has "a right to economic security and to a decent standard of living . . . [and] a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities."

56. Id. art. IV states:

Whenever possible, the mentally retarded person should live with his own family or his foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

57. Id. art. V declares that a mentally handicapped individual has "a right to a qualified guardian when this is required to protect his personal well-being and interests."

58. Id. art. VI guarantees to a mentally handicapped person "a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offense, he shall have the right to due process of law with full recognition being given to his degree of mental responsibility."

59. Id. art. VII states that every subscribing nation shall provide "proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right to appeal to higher authorities."

passes a wider class of beneficiaries, defining a disabled person as anyone deficient in the physical or mental capabilities required for ensuring the necessities of life. Its tone is unequivocal and inclusive. The basic rights set forth in this declaration are granted to "all disabled persons without any exception and without distinction or discrimination" on any invidious grounds. Regardless of its origin, nature, or seriousness, a person's disability is not to impair the equality of his fundamental rights or the inherent right to respect for his human dignity. Article 7 of the Declaration on the Rights of Mentally Retarded Persons, incorporated by reference into the Declaration on the Rights of Disabled Persons, applies to any possible limitation of rights for mentally disabled persons, and requires procedures containing "proper legal safeguards against every form of abuse." Other rights parallel those of the 1971 declaration but are more specifically expressed. In lieu of a provision on guardianship, article 5 declares that disabled persons are entitled to measures "designed to enable them to become as self-reliant as possible." Their need for effective legal aid is also clearly recognized: "Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property."

Human rights declarations of the United Nations represent the solemn pledges of its member states to take effective action toward realizing those stated principles. It is now understood that the observance of these fundamental human rights is no longer a matter for the exclusive domestic jurisdiction of nations, but has become a "matter of legitimate concern for the United Nations and its members." Moreover, articles 55 and 56 of the United Nations Charter constitute an imperfect, yet controversial, legal

61. Id. art. 1. This section guarantees protection for "any person unable to ensure by himself or herself wholly or partly the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities." Id.

62. Id. art. 2. The prohibited grounds of discrimination include not only the traditional grounds of race or sex, but also "state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family." Id.

63. Id. art. 3.

64. Id. art. 4.

65. See, e.g., id. art. 6 on social and health services which refers to "the right [of disabled persons] to ... psychological and functional treatment ... vocational education ... counselling, placement services and other services which will ... hasten the process of their social integration or reintegration." See also id. arts. 7 & 9.

66. Id. art. 5. For other new provisions, supportive of self-reliance see article 12 (organizations of disabled persons shall be "usefully consulted in all matters regarding the rights of disabled persons") and article 13 ("[d]isabled persons, their families and communities shall be fully informed by all appropriate means of the rights contained in this Declaration.")

67. Id. art. 11.

68. 1 H. LAUTERPACHT, OPPENHEIM'S INTERNATIONAL LAW 740 (8th ed. 1955).
obligation on the part of member states to take "joint and separate action" to achieve "universal respect for, and observance of, human rights and fundamental freedoms for all." With this objective recited in their preambles, the declarations on the rights of mentally retarded and disabled persons, like the Universal Declaration of Human Rights which also incorporated this goal, may have some juridical character as an elaboration of those articles of the Charter of the United Nations. These declarations do not have the legally binding power of a convention and certainly have not been drafted and adopted in the form of an international treaty, yet even a lack of clear definitional and enforcement provisions does not deprive them of an obligatory character.

Moreover, the declarations of 1971 and 1975, like their predecessors, have a potential for considerable indirect legal effect on the constitutions, legislation, and judicial decisions of various nations. They also may serve as a "code of conduct" and as a yardstick for measuring "compliance with international standards of human rights." Already there are indications that the 1971 declaration has had such an impact. For example, in the United States a federal court decision upholding the right to habilitation and minimum guarantees of decent services for institutional residents cited to article 2 of the declaration.

Clearly, the declaration is only as valuable as the activity and discussion it provokes. People ignorant of their rights have little advantage over those without any rights at all. Public authorities, professional associations, and

69. U.N. CHARTER art. 56.
70. Id. art 55.
73. 1 H. LAUTERPACHT, supra note 68, at 740 observed:

Far from detracting from the obligatory nature of these articles, [the Universal Declaration] imposes upon the members a moral—and however imperfect, probably a legal—duty to use their best efforts, either by agreement or, whenever possible, by enlightened action of their own judicial and other authorities, to act in support of a crucial purpose of the Charter.

75. See notes 16-20 & accompanying text supra.
76. Wyatt v. Stickney, 344 F. Supp. 387, 390 (M.D. Ala. 1972), aff'd sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). Writing for the court, Chief Judge Frank M. Johnson, Jr., stated: "[t]he Court's decision with regard to the right of the mentally retarded to habilitation is supported not only by applicable legal authority, but also by a resolution adopted on December 27, 1971, by the General Assembly of the United Nations." Id.
organizations of, and on behalf of, disabled persons need to know of these international standards.77 Armed with these documents, they may better identify flaws in existing legislation and its implementation and move to correct them.78

Since 1974, a task group appointed by the ILSMH has examined ways to implement the 1971 declaration. Chaired by Dr. Elizabeth M. Boggs, this five-member committee reported its recommendations to the ILSMH’s Sixth World Congress and its 1976 General Assembly.79 The task group report and the interviews from this study reveal many uses of the declaration. As a frame of reference for protecting human rights, it may support arguments for progressive legislation,80 illuminate issues framed for judicial resolution,81 inform professional groups on ethics and standards,82 educate the public and influence its attitudes toward the disabled,83 remind public authorities of fundamental national commitments, promote international guidelines on legislation and service provisions,84 and provide a benchmark

77. The United Nations Declaration on the Rights of Disabled Persons, supra note 60, art. 13, provides that disabled persons, their families, and communities should be informed of their rights under the declaration.

78. In cooperation with its member societies, the ILSMH makes considerable efforts to circulate these documents. See Int’l League of Societies for the Mentally Handicapped, Recommendations and Resolutions 2 (Feb. 1976).

79. To date, the task group has drafted analytical guidelines to the articles of the declaration, presented the results of this author’s survey report, discussed the merits of social legislation, judicial action, and collaboration with governments as ways of realizing rights, and planned a program of public education. For a discussion of other activities of the task group and its members, see Shearer, Mental Handicap, 33 NEW Soc’Y 699 (1975).

80. The use of the declaration to support legislation was the utilization most frequently noted in the course of this author’s survey, particularly in Sweden and the Netherlands. There are many American references to the declaration, some of which have been collected by Dr. Elizabeth Boggs. These include citation by the United States Senate Committee on Labor and Public Welfare in S. REP. No. 1169, 93d Cong., 2d Sess. 33 (1974).


82. See, e.g., AMERICAN ASS’N ON MENTAL DEFICIENCY, RIGHTS OF MENTALLY RETARDED PERSONS (1972). The Social and Legislative Issues Committee of the American Ass’n on Mental Deficiency (A.A.M.D.), developed a series of position papers, officially adopted by the A.A.M.D. Council, on specific ways of implementing and interpreting the declaration and other rights.

83. The declaration has been translated in all countries surveyed and has been widely available. It has been reprinted in the United States in E. Ogg, SECURING THE LEGAL RIGHTS OF RETARDED PERSONS 27 (1973) and in CENTURY OF DECISION, supra note 11, at 101.

84. Many observers believe that the rights of mentally handicapped persons will not be effectively achieved, except in the form of binding instruments and statutes “specific enough to produce genuine reforms in the different states.” Mertens, Whose Rights Are
for negotiations leading to a concrete expression of the declaration's aspirations within particular domestic jurisdictions. Given appropriate international and national machinery, it could provide a basis for ongoing monitoring of governmental responses and identification of models of positive compliance.

The application of these principles requires some knowledge of the rights of retarded citizens of a given country. Relying heavily on interview data, this article attempts to inventory human rights developments against the background of the 1971 Declaration on the Rights of Mentally Retarded Persons.

III. SWEDEN: THE SEARCH FOR ENFORCEMENT STRATEGIES

Sweden pioneered mental retardation services based on integration and respect for individual differences. Under the rubric "normalization principle," Scandinavians elaborated an ideology and a framework for egalitarian

85. Through questionnaires, visits to the surveyed countries, and interviews with voluntary association leaders, government officials, and other interested individuals, the author obtained some assessment of human rights progress in the mental retardation field. Much of the information forming the basis for these assessments is the result of interviews with leaders of national voluntary associations who were asked to compare their own national laws and practices against the standards of the United Nations Declaration on the Rights of Mentally Retarded Persons. In 1973, the author prepared and distributed an 18-point questionnaire. The questions, examining steps to be taken to implement and enforce the 1971 declaration, were grouped into eight categories, with the two core questions being: "Do the existing laws of your country require similar guarantees as those set forth in the Declaration?" and "In your experience, to what degree are those rights applied in practice in the lives of the retarded of your nation?" With modification to elicit the unique features of a surveyed country's laws, institutions, or provisions, the questionnaire provided a common framework for the respondent's observations. Replies were generally oral rather than written, although documents and reports were sometimes included.

86. The "normalization principle" in essence regards the person with a disability as a normal person rather than as a deviant. Hence, the goals of services for the retarded person, and the means of achieving those goals should to the greatest extent possible resemble the norms of his or her culture. See NATIONAL INSTITUTE ON MENTAL RETARDATION, NORMALIZATION: THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 28 (W. Wolfensberger ed. 1972). The Scandinavian countries have achieved considerable progress toward this end. See K. GRUNEWALD, THE MENTALLY RETARDED IN SWEDEN 5 (1974). Grunewald stated:

Normalization does not imply any denial of a retarded person's handicaps. It involves rather exploiting his other mental and physical capacities, so that his handicap becomes less pronounced. It also means that the retarded person has the same rights and obligations as other people, so far as this is possible.

Id. See also L. LIPPMAN, ATTITUDES TOWARD THE HANDICAPPED 15 (1972); B. Nirje, The Normalization Principle and Its Human Management Implications, in PRESIDENT'S COMM. ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR
legislation and practice. Although justifiably proud of generally high standards of care, Swedes realize that blemishes remain. In some places, special hospitals offer little more than safe custody for the troublesome inmate. In addition, the relative autonomy of county governments in Sweden frequently leads to uneven service provisions for retarded persons. Therefore, despite remarkable legislative and social gains for the retarded, there are, as Dr. Sterner, an officer of the Swedish National Association for Retarded Children, observed, "still many gaps and shortcomings."

A. Legislative Patterns: The Provisions Act and its Implementation


Legislation embodying specific human rights is at the core of Swedish success. Under the Provisions Act, county councils must provide retarded persons with a range of community-oriented services. These services supplement social welfare benefits that mentally retarded Swedes share with other nonhandicapped and handicapped citizens. The Provisions Act establishes rights to habilitation services adapted to individual needs and supplants laws which emphasized residential institutions for and special education of "educable" retarded children. It is designed to offer specialist services in the community to even the most severely handicapped.

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89. *See* pp. 228-32 infra.
91. *Id.* § 2.
94. The Provisions Act § 1 declares: "This law concerns those who, due to retardation in their mental development, need special care and services from the community for their education, training, and integration in the community." (Translation by B. Nirje, *supra* note 92, at 8.)
The Provisions Act has been hailed as "a Bill of Rights for the mentally retarded." As an expression of the normalization principle, it makes available educational opportunities to all retarded children and young persons, domiciliary and support services to mentally retarded persons living at home, less restrictive accommodations—group homes and hostels—for those who do not need more sheltered environments, preschool education and training, free medical and dental care, and day activity centers for unemployed adults not living in the community.

As a general principle, the costs of relieving a disability are borne by the public, not the disabled individual. Only adult retarded persons earning income are charged reasonable board and lodging fees. Otherwise, basic care and ancillary services such as dental care, speech therapy, physiotherapy, health and medical services, day nurseries for children, and day activity centers for adults, are rendered free of charge to the retarded person and his family. Under section 16 of the Act, county councils, whose taxes finance most of these services, must draw up comprehensive service plans. Subject to the approval of the National Board of Education and the National Board of Health and Welfare, these plans can be ratified for five years. This enables the councils to receive state grants for construction and modification of special schools, residential institutions, and day care centers for adults. Furthermore, state grants cover almost 95 percent of the salaries of special teachers. In short, the Act constitutes an impressive instrument for generating dispersed services for retarded people.

a. The Pace of Implementation. Although Dr. Sterner has noted that there are practical difficulties in its implementation, he believes the Provisions Act has been effective. Legislative standards, he observed, have been extremely significant in spurring "quite substantial improvements that could easily be documented, statistically or otherwise." Dr. Grunewald, the

95. B. Nirje, supra note 92, at 1.
96. The Provisions Act applies to those who by reason of retarded mental development require these special services—some one percent of the Swedish population. R. Sterner, supra note 4, at 6-8.
97. K. Grunewald, supra note 86, at 51.
98. Interview with Dr. Richard Sterner in Dublin (Sept. 15, 1975).
99. Dr. Sterner has said:

Implementation [of the Act], on the whole, has been rapid, but is not yet complete. It suffers from shortages of trained staff and specialists, such as physicians, physiotherapists, speech therapists, and training teachers. Retarded persons with physical handicaps often receive less satisfactory services for these additional handicaps than do corresponding persons with normal intelligence—which is just one out of many examples on how we have not yet succeeded with the difficult task of providing adequately for all those with multiple handicaps.

Sterner, supra note 89, at 4.
head of the Swedish Agency that oversees Retardation Services, shares this view. He remarked that in approving plans and granting funds for the mentally retarded, the National Boards “are greatly aided by the fact that no other group in Sweden has its social, pedagogic, and medical needs and rights so firmly and in such detail prescribed by law.”

In recent years, the speed of implementing the Act and the scope of county responsibilities under it have become matters of public debate. There are signs of strain between the central state agencies with their supervisory functions and the county governments which actually provide direct services. Dr. Sterner attributes this strain to the emergence of “a state’s rights ideology” on the part of some counties and to growing resistance against increases in local taxes. Some counties claim, as a matter of “county’s rights,” that they should be free to determine their own levels of financial outlay for mental retardation services. The Swedish National Association for Mentally Retarded Children (FUB) has countered by arguing that financial stability in local government “must be attained by other means than by sacrificing the interests of the weakest members in the community.”

County reaction has focused on central state agency inspection powers, public access to inspection reports, and central powers to upgrade substandard services. Some county boards complained that National Board of Health and Welfare inspections and reports forced them to increase financial outlays and that they did not receive the reports before they were released to the press. As a result, counties now receive prior notification of deficiencies, but the

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100. K. GRUNEWALD, supra note 22, at 13.
101. Interview with Dr. Richard Sterner in Dublin (Sept. 15, 1975). On the initiative of the Treasury, counties have agreed to limit these rate increases. Id.
102. The National Association for Mentally Retarded Children, known as FUB, is one of the strongest parent-sponsored voluntary organizations of its kind. It has about 100 local branches and 10,000 members in a country of eight million people. R. DYBWAD, INTERNATIONAL DIRECTORY OF MENTAL RETARDATION RESOURCES 249 (HEW Pub. No. (OS) 73-77, 1971).
103. Sterner, supra note 89, at 14. Dr. Sterner elaborated:
   A couple of years ago, in comparing this country [Sweden] to America, I was wondering about the fact that in this country we have had very little state’s rights reaction against the Act for provision for mental retardation, because after all, it provides for certain rights for the mentally retarded. It appoints two state agencies and entrusts them with a supervising power. They write all rulings which are based on the Act, which are adopted by the government. They interpret the Act, and they can change their minds as science and experience develops. And they do. And up until two years ago, there was no reaction against this kind of setup on the basis of the state’s rights ideology. But now it has come. So this is a new development in Sweden.
   Interview with Dr. Richard Sterner in Stockholm (Apr. 8, 1974).
104. Id.
Minister for Social Affairs has assured Parliament that inspections will continue and their findings will not be concealed from the press.  

2. Access to Education

   a. The Statutory Framework. By law, every Swedish retarded child is entitled to a free and suitable education. Prior to the Provisions Act, only retarded children considered "educable" were covered by compulsory education laws. Under the repealed 1944 education act, schooling was mandatory only for those capable of absorbing at least a simplified version of an elementary school education. Under current law, compulsory education for the retarded person begins at age 7 and generally continues as long as instruction is required up to the age of 21, and in exceptional cases until age 23. This statutory scheme is somewhat flawed by section 24 of the Provisions Act which, on its face, can authorize some school exclusions—special school attendance is compulsory for mentally retarded children "who can profit from education", but who are unable to participate in educational training within the general education scheme.

   Required educational services aim to keep the pupil in as normal an educational setting as possible. The retarded child, as a matter of right, is entitled to a preschool education up to age 7. If no preschool classes are available in his district, the child has a right to five hours of home teaching per week. In contrast to the regular nine years of schooling,
retarded children are subject to at least a 10-year period of compulsory education. Beyond these 10 years of education, the National Board of Education requires a 4-year curriculum of vocational education or work training.113

Recent administrative directions and proposals construe Swedish law as requiring education for all citizens. To effectuate this principle, the National Board of Education adopted proposals for special resources for severely retarded children and for adolescents with severe sight and hearing impairments. It is also advocating "activity training" for young adults considered unable to profit from work training.114 A more explicit statutory guarantee of universal educational training, however, might prompt fuller realization of the 1967 legislative purpose.115

b. Principles in Action. Sweden has experienced a steady growth in special education enrollments for the mentally retarded.116 A small fraction

some retarded children receiving this "separate" education are capable of absorbing much more than they are actually taught. Id.

113. K. GRUNEWALD, supra note 22, at 35. Since 1967, the number of retarded pupils attending special education courses has nearly doubled. R. Sterner, supra note 4, at 33.

114. Dr. Sterner, in reviewing the range of mandatory special educational services, has observed that it is recognized in the law that "there is [nobody] who, because of severe or profound mental retardation, often combined with other handicaps, would be unable to benefit from at least some training or other form of pedagogical stimulation." R. Sterner, supra note 107, at 2.

115. Swedish government statistics compiled as of May 1973 identified 779 children and adolescents, from among the 13,759 of such persons registered as mentally retarded, as "not taking part in any activity." Over half of this group were living with their parents, while nearly a third were in residential homes. Swedish Bd. of Health & Welfare, Provisions and Services for the Mentally Retarded in Sweden (1973). By November 1975, the number of such persons dropped to 454 out of 13,783. Memorandum from Dr. Sterner to the author (Sept. 3, 1976).

116. A comparison of 1970 and 1973 statistics gives some idea of the positive trend. In 1970, some 11,140 children and adolescents received some form of special schooling for the mentally retarded. This represented a near doubling of the 1965 figure, and an increase of 14 percent over the preceding year's enrollment. This 1970 figure consisted of some 1,300 children in preschool programs (two per 1,000 of all Swedish children aged 3 to 6); 8,000 in elementary schools (7 per 1,000, aged 7 to 16); and 1,860 in vocational or further training programs (5 per 1,000, aged 17 to 20). At that time, 857 mentally retarded children and adolescents of compulsory school age were registered by the authorities as not receiving any education or training at all.

The May 1973 school statistics were as follows: 1,403 in preschools and day nurseries; 4,594 in basic schools; 2,767 in training schools; 2,804 in vocational schools; and 1,686 in homebound or "separate teaching." In total, 12,980 retarded children and young people were receiving some type of education and 779 were receiving no training whatsoever. Swedish Bd. of Health & Welfare, Provisions and Services for the Mentally Retarded in Sweden (1973). For a more detailed discussion of Swedish special educational provisions, see G. Katz, Sex Education for Mentally Retarded Adults
of the retarded, however, remain without the instructional programs guaranteed them by law. Approximately three percent of those registered as being mentally retarded participate in neither educational nor other activity programs.\textsuperscript{117} In light of this continuing problem of educational exclusion, the FUB, on February 14, 1974, presented a list of demands for better services to the Federation of County Councils.\textsuperscript{118} One of the 19 items listed was insufficient educational and training provisions for some severely handicapped children. When FUB's request for firm remedial timetables was refused, the Association's leaders began to consider seeking judicial and other relief.\textsuperscript{119}

Among various channels for complaint, a parent dissatisfied with a child's educational placement, or lack of one, can apply to one of Sweden's regional decisions committees for a different placement.\textsuperscript{120} To be enrolled in a special school, residential home, or special hospital, the retarded person must undergo an admission procedure which usually requires a medical certificate and a psychological, educational, and social investigation and evaluation of his need for special provision. When the retarded applicant is age 15 or over, the admitting authorities should solicit his opinion as to his enrollment, if he is capable of expressing one. If either he or his parent withholds consent to a particular admission, the decisions committee can decide what, if any, form of enrollment is appropriate. However, as Judge Erik Alexanderson, President of Stockholm's decision committee, acknowledged in an interview, very few cases are referred for committee review.\textsuperscript{121}

Even if residence away from home is required, the Provisions Act was intended to provide educational services in as integrated a setting as possible. Lennart Wessman, inspector of special schools for the National Board of Education, described the majority of counties as having "one large boarding school and a number of small day classes or schools."\textsuperscript{122} In accordance with the Act, he envisions the planning and organization of residential units of intimate size.\textsuperscript{123} Wessman sees no reason why handicapped

\begin{footnotes}
117. \textit{See} note 115 \textit{supra}.
118. Interview with Allen Everitt, FUB Executive Director, in Stockholm (Apr. 9, 1974).
119. \textit{Id}.
120. \textit{See} Organization of Special Education in Sweden, \textit{supra} note 116, at 5.
121. Interview with District Court Judge Erik Alexanderson in Stockholm (Apr. 9, 1974).
122. Organization of Special Education in Sweden, \textit{supra} note 116, at 5.
123. Mr. Wessman observed: "All new buildings for living activities should be mixed
\end{footnotes}
pupils should attend segregated schools and points to a misguided protectionist outlook in traditional segregated education.\textsuperscript{124} Dr. Grunewald reports similar findings: that the fear that retarded children might be "persecuted" by other children has proven "unjustified," provided other children and their parents are given the "right sort of information."\textsuperscript{125} The National Board of Education is therefore attempting to integrate all the retarded pupils now in separate schools into special classes in ordinary schools.\textsuperscript{126}

Another important educational development is the growth of adult education programs. Thousands of mentally retarded adults now take part in subsidized study circles and other forms of part- and full-time education and vocational training. Since more than 10,000 mentally retarded adults never received the special education to which pupils are now entitled, there is a great need for these study circles, extended vocational habilitation services, and special courses in "folk" high schools and colleges.\textsuperscript{127} Adult education has not increased more rapidly because of shortages of teachers with the necessary qualifications, lack of accommodations for the multiply and severely handicapped persons in special state schools, and problems in making special instructional materials more readily available.\textsuperscript{128} Through continuing educational contacts between nonhandicapped and handicapped persons from preschool to adult education levels, the Swedes hope to instill a better self-image for the retarded person and even greater public acceptance of his place in society.

3. Access to Treatment in Residential Settings

\begin{itemize}
  \item \textbf{Legal Standards.} The Provisions Act redresses old imbalances in the
\end{itemize}

with the built quarters of the town and the units not bigger than 5-6 pupils. Also the care homes ought to be small units in the town or at least small units within the institution." \textit{Id.} at 6.

\textsuperscript{124} Mr. Wessman explained:

\begin{quote}
  In the past we have overprotected the mentally handicapped in school and in living. And we have also protected society from the handicapped. \[However,\] \[w\]hen we now try to integrate them we find, often to our surprise, a very positive attitude from society to accept them as they are with their handicap.
\end{quote}

\textit{Id.} at 6.

\textsuperscript{125} \textit{See K. GRUNEWALD, supra note 22, at 30.}

\textsuperscript{126} \textit{Organization of Special Education in Sweden, supra note 116, at 6.}

\textsuperscript{127} Those attending folk high schools and colleges are entitled to have fees, including services incidental to caring for their disability, paid for by the government. \textit{Brattgard, Sweden: Fokus, a Way of Life for Living, in THE HANDICAPPED AND THE COMMUNITY, supra note 87, at 38.}

\textsuperscript{128} Dr. Sterner noted that another service deficiency is the insufficient number of occupational day centers, resulting in retarded adults "waiting in line \[when they\] can justly claim that a legal right of theirs has not been honored." Interview with Dr. Richard Sterner in Dublin (Sept. 15, 1975).
availability of residential and nonresidential treatment. It also provides for care at home when possible, and authorizes accommodations in the community for those who do not need residential care in an institutional setting but cannot live at home. To achieve the Act’s objective, the Swedish Division for Mental Retardation has outlined certain principles for the “normalization” of residential care: All services for retarded persons must be regarded as equally important as services rendered to others; priority for 24-hour-a-day services to those in residential homes must be abolished; and specialists organizing services and supervising staff must not be affiliated exclusively with institutions.

The National Board of Health and Welfare encourages client participation in planning services. In providing residential care, according to Dr. Grunewald, every attempt is made to avoid compulsory admission. Substituted consent by parents or guardians, however, is deemed sufficient to effect voluntary admission of a resident. A mentally retarded child under 15 years of age may be admitted to a residential home or special hospital on the consent of his parents or legal guardian. Above that age, the retarded person can be “voluntarily” admitted on his own consent (if he is capable of expressing it), or on his guardian’s approval if he is incapable. Day or group home care, however, may not be involuntarily imposed.

Regardless of residence, the Swedish retarded person’s “legal capacity and right of self-determination are fundamental rights and should only be circumscribed in explicit aspects.” Spokesmen for the National Board

129. Section 4 of the Provisions Act states that “[r]esidential institutions, special hospitals, day centers for children, and occupational centers shall be provided for the care of the mentally retarded, and there shall be special residential institutions for those mentally retarded who need care in residential institutions with special arrangements.”

130. Section 4 of the Provisions Act also states: “The mentally retarded who need care according to this law, but who do not need care in an institution as referred to above in the first section, shall be provided with care in their own homes.”

131. Section 5 of the Act provides: “Accommodation in other private homes, boarding homes or student hostels shall be provided for those mentally retarded who cannot stay in their own homes but who do not need to live in a residential care institution or special hospital.”


133. Interview with Dr. Karl Grunewald in Stockholm (Apr. 8, 1974).

134. K. GRUNEWALD, supra note 22, at 50.

135. Id. Under section 24 of the Provisions Act, however, school attendance can be made compulsory as long as the mentally retarded person “needs training.” This compulsion generally ends when one reaches the age of 21, although for exceptional reasons compulsory education may be prolonged through age 23.

also recognize the retarded person’s “right to self-expression, participation and acceptance.” Self-determination is fostered in several ways. The National Board, by administrative directive, requires that treatment conferences and meetings be held with clients in attendance. Such treatment conferences are held periodically to plan and evaluate each client’s treatment plan. These conferences must include the retarded person himself, “unless the nature of the discussion suggests otherwise.” Under the directives of October 1973, chiefs of service programs (including special hospitals, residential homes for children and adults, group homes for adults, day centers for adults, and day nurseries) are responsible for organizing meetings of the service recipients themselves and meetings of their parents and other representatives. The meetings are intended to give the retarded person input into decisions regarding his treatment. Their purpose is threefold: to provide the group with useful information, to give the staff an opportunity to respond to the group’s “demands and desires,” and to stimulate individual members to “actively participate in the shaping of his own conditions and circumstances.”

For the most capable clients, these periodic meetings should be handled without any assistance from, and possibly even without the attendance of, the staff of the service program.

Meetings are arranged twice a year between service providers and the consumer’s representatives. These gatherings of relatives, guardians, or other spokesmen are seen as a basis for an increased cooperation leading to active initiatives of different kinds, such as recommendations to service

137. These rights include
the right [of a retarded person] to be listened to, even if he cannot express himself in a conventional manner, to make choices and to become accepted by and integrated into the community . . . [and] the right to shelter in the community of his own choice, so as to minimize the need for institutionalized care. Id.
139. Id. at 2-3.
140. Id. at 4. To illustrate the subject matter of these meetings, the directive explains: “The content is decided by the capacity and the desires of the mentally retarded participant. Rules for work in residential life belong here, and also acquisitions for common use, the disposition of guaranteed funds, travels, educational programs, leisure time programs, etc.” Id. The directive further guides program directors by stating:
In the most simple form of meeting, only one subject needs to be taken up. The subject shall be concrete and of concern for the participants. If so desired, decisions can be taken, e.g. on presentations to authorities or their representatives. Actions decided shall, if possible, be implemented directly after the decision. If needed, minutes of the decisions of the meetings shall be kept. Id.
141. Id. at 5.
boards and the formation of task forces. These meetings are a step toward greater autonomy for the clients who attend.

In exceptional cases, Swedish law authorizes modes of compulsory care for mentally retarded individuals. Under the Child Welfare Act, a retarded person under age 15 may, without consent of parent or guardian, be committed to care. More significantly, civil commitment provisions allow a retarded person to be admitted to a residential home or special hospital against his will or that of his parents or guardian. Very few admissions are reviewed by a decisions committee or by the national commission on applied psychiatry. Yet the criteria for involuntary commitment are broad and uncertain. Although "closed" (secure) care is discouraged unless "absolutely necessary," the law authorizes commitment if a person is mentally retarded, and:

(a) constitutes a danger to the personal safety, physical or mental health of another person, or to his own life;
(b) is incapable of looking after himself;
(c) is incapable of protecting himself against sexual abuse; or,
(d) behaves in a manner gravely disturbing to persons living in the vicinity, or others.

These vague criteria are rather subjective standards upon which to deny an individual's liberty. They single out retarded persons for reasons far removed from conventional police power and parens patriae rationales. Thus the statute permits, as an independent ground for commitment, conduct which is not physically dangerous, but is distressing to certain sensibilities (that is, behavior affecting another's "mental health" or "gravely disturbing" to others). These criteria are surely too subjective and capricious to furnish reliable and uniform guides for state intervention.

In contrast, only after judicial findings of guilt for a crime may a retarded person be committed by a court of law. Providing there is sufficient mental capacity to be held criminally responsible, the mentally disordered offender may be sentenced to a fixed term of years or to an internment without time limitations. The Swedish Penal Code authorizes placement in either a special hospital or in an open care facility.

142. See K. Grunewald, supra note 22, at 49.
143. See id.
144. See id.
147. Chapter 31, section 3 of the Swedish Penal Code states:
If a person who has committed a criminal offense can be provided with care
b. Residential Care Services. Sweden acknowledges that the policy of care in large institutions is costly and self-defeating. Consequently, planners are accelerating the relocation of retarded individuals from larger to smaller facilities and from self-contained "total institutions" to small group living in ordinary housing. In fact, in the next decade the Stockholm County Council plans to place all children needing residential care in small family-sized units. Dr. Robert Binda finds that these normalized settings

under the Law on the Provisions of Closed Psychiatric Care in Certain Cases or care in a mental hospital under Section 35 of the Law Concerning the Treatment of Certain Mentally Disturbed Individuals, the court may, if it finds the need for such care established, order his surrender for mandatory care at an institution for the mentally ill or an institution for the feeble-minded. If the act was not committed under the influence of mental disease, feeble-mindedness or other mental abnormality of such profound nature that it must be considered equivalent to mental disease, such order may, however, be made only if special reasons dictate it.

THE PENAL CODE OF SWEDEN, ch. 31, § 3, supra note 146, at 94-95. The court may also order "open psychiatric care if, for special reasons, no more far-reaching measure is deemed required." Id. at 95 § 4.

148. See also K. GRUNEWALD, supra note 22, at 24-29; R. STERNER, SERVICES FOR THE HANDICAPPED IN SWEDEN (1972).

149. Dr. Robert Binda, a leading Swedish research psychologist, concludes:

[L]arge institutions are subversive or at least developmentally restrictive to all people, the mentally retarded included. Smaller hostels give a much more stimulating milieu both to the staff and the retarded. The question is not whether the retarded, even the severely and profoundly, are able to handle some type of normalized living but how the residential system should be organized.


Dr. Grunewald has identified the Scandinavian countries as having moved from the "specialization" stage in which services are centralized (that is, a single institution is created to service a large part of the country) to the "differentiation" stage at which services become increasingly nonstandardized. He sees as the last stage in service delivery a system which is characterized by decentralization and access to generic social services. K. Grunewald, The Guiding Environment: The Dynamics of Residential Living 2 (U.S. Dep't of Health, Education & Welfare Pub. No. (SRS) 72-25004 (1972)).

At the time of this author's visit to Sweden, of those persons registered as mentally retarded and eligible for special services, 43 percent lived in parental homes, 33 percent in residential facilities ("residential homes" for adults or children), 7 percent in boarding schools and homes, 4.5 percent in special hospitals, 3.6 percent in group homes, 3.3 percent in foster or other private family care, and 4.2 percent in their own homes. Overall, Binda has estimated that more than 50 percent of the adult mentally retarded lived in what are, for Sweden, big institutions and hospitals, and only 10 percent, mainly the mildly and moderately retarded, have been integrated into the community. R. Binda, supra at 20.

150. Letter from Dr. Richard Sterner to author (Sept. 3, 1976). The Stockholm County Plan, prepared by the County Mental Retardation Service Board for 1977-87, provides a detailed plan for such changes as abolition of the use of special hospitals, with the gradual substitution of intensive treatment in small units, marked reduction of
“give strong evidence that even the more handicapped mentally retarded and also other groups, e.g. emotionally disturbed people, have much better possibilities for developing in small integrated hostels if they are provided adequate training, assistance, and a stimulating environment.” Dr. Grunewald concludes that the case for smaller residential settings is compelling.

How far is Sweden from attaining the goal of total conversion from institutional to normal living settings? Ordinary residential institutions for adults averaged 77 residents and those for children averaged 47. Two institutions, however, numbered more than 400 residents (there were six such institutions in 1969). These institutions, the so-called “special hospitals”—or as some call them, the “waste heaps”—are organized on a regional basis. The following analysis, however, need not recount the statistics of residential care, the philosophy of normalization, or its generally impressive applications. Instead, the special hospital problem will be examined in its human rights dimension.

Two contrasting types of retardation facilities were visited by the author. One was the Salberga Hospital in Sala, the largest of the special hospitals, and the other was the residential home for children and adults at Sätter, which probably is a more typical county institution. The two institutions provide a striking contrast.

At Sätter, one can observe programmed efforts to provide each resident with a stimulating environment. The staff shows an awareness of their clients' needs for contact with, and reentry into, the outside world. Small
details give concrete meaning to pledges of normalization and respect for individual differences.\textsuperscript{158} Nationally, this concern is demonstrated by an increase in group homes and improvements in institutional standards.\textsuperscript{159} For example, only 40 group homes were operating in 1969. Four years later there were 186.\textsuperscript{160}

The special hospitals compared unfavorably in their living conditions. Of 1741 inmates, 17 percent were quartered in rooms with 6 or more beds, nearly 95 percent were in wards with 13 or more persons, and 80 percent were segregated by sex.\textsuperscript{161} While 70 percent of 10,400 residential places for the retarded had good or at least acceptable standards, the situation “is considerably worse at the special hospitals, where only about 30 percent of the places were of acceptable standard.”\textsuperscript{162} Six special hospitals house some 1200 adults and children, a number which other care facilities have been unable or unwilling to manage. Under pressure from the National Board of Health and Welfare, the number of persons in the special hospitals is slowly declining; now 13 percent of all retarded adults requiring full-time care are in such hospitals, as compared to 17 percent in 1969.\textsuperscript{163}

Special hospitals have had a dual function: To provide secure custody for so-called “anti-social retarded people”\textsuperscript{164} and to provide special medical care and other services for severely or multiply handicapped persons. However, the need for these isolated hospitals is repeatedly questioned. Most of them are regarded as “awkwardly situated,” and are criticized for keeping foster placements, and that newspaper advertising for foster parents had brought 40 responses from prospective substitute parents.

\textsuperscript{158} For example, on the visit to Sätter, an adult resident welcomed the author into his well-designed and decorated single room, proudly showing the record player he had earned with his sheltered employment wages. Children displayed a great variety of toys, musical instruments, and games available for their play.

\textsuperscript{159} See also Swedish Bd. of Health & Welfare (Socialstyrelsen), Living Standards in Swedish Facilities for the Mentally Retarded (May 15, 1972). This 1971 audit of living standards in all residential facilities revealed the average number of residents per sleeping room to be less than two. Of these bedrooms, 48 percent were singles and 34 percent were doubles, but 3 percent combined 5 beds or more, with some dormitories having as many as 11 beds. Nearly 70 percent of the primary living units had no more than 12 residents and just over a third of them had both male and female residents. \textit{Id.}

\textsuperscript{160} Group homes averaged 7 residents per home and served 1340 mentally retarded adults. Provisions and Services for the Mentally Retarded in Sweden, \textit{supra} note 115.

\textsuperscript{161} Living Standards in Swedish Facilities, \textit{supra} note 159.

\textsuperscript{162} See K. Grunewald, \textit{supra} note 22, at 42.

\textsuperscript{163} In actual numbers, there has been a decline from some 2000 residents in 1970 to less than 1200 in 1975. Interview with Dr. Karl Grunewald in Dublin (Sept. 16, 1975). As of September 1976, this 1200 figure had remained intact. Memorandum from Dr. Richard Sterner to the author (Sept. 3, 1976).

\textsuperscript{164} K. Grunewald, \textit{supra} note 22, at 44.
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some persons who do not really require care in special hospitals.\textsuperscript{165} They are further attacked because of their size, their separation from the community, their disruption of familial and other social ties of inmates, their custodial forms of confinement, and their unduly restrictive care. In 1969, Dr. Grunewald wrote that in “a few deplorable institutions the retarded have to live as many as ten to a room, with large, inadequate dayrooms which serve as many as 25 to 30 persons.”\textsuperscript{166} One of the subjects of Dr. Grunewald’s criticism, Salberga Hospital, the largest of the Swedish retardation institutions, contained over 700 patients in 1969. Five years later the number was down to 446.\textsuperscript{167}

Nationally, the number of involuntarily committed retarded persons is decreasing. Of 900 adults confined on grounds of antisocial behavior in the late 1960’s, at least 400 have been transferred to less restrictive forms of accommodation, and 100 have been completely discharged as being neither mentally retarded nor in need of care. Yet, it has been estimated that of the 900 retarded adults remaining in special hospitals, only 250—3 per 100,000 of the Swedish population—require this custody.\textsuperscript{168}

In four years, new admissions at Salberga have been halved.\textsuperscript{169} But in the past, according to Dr. Hindhede, Salberga’s chief medical officer, a number of residents should never have been admitted to a mental retardation facility.\textsuperscript{170} On first taking over at Salberga, Dr. Hindhede reviewed the status of all the residents. In two years, he discharged some 50 persons because they did not require secure treatment, and he urged that still more should be discharged.\textsuperscript{171}

\begin{itemize}
  \item \textsuperscript{165} Interview with Dr. Grunewald in Stockholm (Apr. 8, 1974). One of these six hospitals provides intensive treatment of limited duration to young retarded persons with locomotive handicaps. This hospital is regarded as exceptional and as operating in “a rational manner as long as many ordinary orthopedic [specialists] fail to give [retarded persons] sufficient services and often do not know how to take care of them.” \textit{Id.}
  \item \textsuperscript{166} K. GRUNEWALD, supra note 22, at 25.
  \item \textsuperscript{167} Salberga Hospital is divided into three clinics: one for adult men diagnosed as “psychopathic” (most of these men are confined to locked wards); another clinic is for young men and women with I.Q.’s below 40; and the third clinic contains children of limited intelligence. Interview with Dr. Hans Hindhede, Chief Medical Officer with administrative responsibilities for Salberga Hospital, in Sala, Sweden (Apr. 11, 1974). (The author wishes to express his appreciation to Dr. Hindhede for making available a considerable amount of documentary material on which this analysis is based, and for his courtesy in giving the author a tour of parts of the Salberga Hospital).
  \item \textsuperscript{168} K. GRUNEWALD, supra note 22, at 45. Dr. Grunewald has recently reestimated this rate as being even lower. Interview with Dr. Karl Grunewald in Dublin (Sept. 16, 1975).
  \item \textsuperscript{169} H. Hindhede, Population Movements, Table D (Salberga Hospital) (informal memorandum, Mar. 10, 1973).
  \item \textsuperscript{170} Interview with Dr. Hans Hindhede in Sala, Sweden (Apr. 11, 1974).
  \item \textsuperscript{171} \textit{Id.}
\end{itemize}
Although all of Salberga's residents are there for special treatment, many do not receive it. On the "psychopathic" wards, residents were observed sitting idle, interned in locked rooms. While some such wards had structured programming and staff who discussed social training projects with enthusiasm, two out of three of the psychopathic residents, as Dr. Hindhede candidly acknowledged, still lacked treatment programs. Residents are still housed in an old, dreary barracks-like structure.

Confinement in the special hospitals has caused sharp controversy. The noted Swedish researcher, Dr. Gunnar Kylén, has spoken out against the barren and prison-like atmosphere of the psychopathic wards. Confined as not responsible for their actions, Salberga residents, he argues, must receive treatment under the least punitive and most comfortable and habilitative regimen possible. While central authorities appear to have adopted a policy of reform by attrition, the county council operating Salberga and the hospital employees nonetheless maintain that the institution is needed. Dr. Hindhede reminds visitors that a valid, custodial function remains to be performed. He dismisses the request of some of the "psychopaths" for confinement in an ordinary prison or mental hospital, explaining that such men "don't fare very well" and might be exploited, financially or otherwise, by more sophisticated inmates. Yet, he believes continued confinement can only be justified by the prospect of beneficial treatment for the patient.

To accomplish habilitation aims, Dr. Hindhede sees a need to reorganize his institution, hire more staff, and find additional money to support treatment programs. The problems of special hospitals, however, are more fundamental than insufficient staffing and funding. Coerced treatment is rarely effective and generally serves to widen the gulf between attendant and patient, which inhibits the latter's cooperation and participation. Some patients will never recover from the sense of injustice that results from indef-

172. See note 167 supra.
174. Id.
175. Interview with Dr. Hans Hindhede in Sala, Sweden (Apr. 11, 1974). Dr. Hindhede explained:
It is sometimes difficult to justify to a patient that he is retained in the hospital, because we can't justify retention on the basis of the treatment given him. We have to justify it by the protection we give society by retaining him, or because the patient has difficult conduct which can't be treated in other units. That justification, in my opinion, is not good enough. The best justification is if he stays here one year he will be made better. We can give that justification for one-third of the [psychopathic] patients. We want to be able to give it for the other two-thirds.

Id.
176. Id.
inite confinement and uncertain diagnostic labeling. Furthermore, a hospital such as Salberga is a "catch-all" facility which brings together a wide range of castoffs rejected by other services. The public's identification of "special hospital" with criminality hinders efforts to reintegrate its residents into society, even though many have committed no crime. Conversely, the more intelligent residents with criminal records are most likely ashamed by placement with the most severely handicapped people. The forced, albeit limited, association between these two disparate groups would seem to do neither any good.

Abnormal environments cannot be expected to produce "normal" behavior. Cell-like rooms, regimented scheduling, seclusion, and other forms of restraint are not normalizing. Inactivity is an acute problem, especially on children's wards when school is not in session. Moreover, a regional facility heightens the resident's isolation from home and community. Perhaps the transfer of residents to more pleasant facilities closer to home would in itself stimulate visitation and other essential outside contacts. For those persons who are rarely visited, parental substitutes, friends, or counselors need to be recruited.

Forced isolation breeds restlessness. Sometimes efforts to restore rights come too late. For example, after long confinement on criminal charges, which if tried might have been dismissed or resulted in only a light jail sentence, some Salberga residents have been discharged as not being mentally retarded. How can they be compensated? Can repetition of wrongful detentions be avoided? Do residents who appear before decision boards to request transfers or discharges have adequate representation? Do these petitioners know of and use legal aid or other counseling services? Moreover, do patients generally have access to information and counseling, independent of that provided by staff, concerning their rights and means of enforcement?

Restructuring special hospitals may resolve some, but not all, of these issues. The decisive question is whether the broad guarantees of Swedish law are attainable by a troublesome and neglected minority. In any event, the special hospital resident has no less a right to decent standards of habilitation than other retarded persons. He ought not suffer a confinement sometimes penal in all but name.

B. Enforcing Rights: Some Swedish Techniques

Every society, no matter how enlightened, needs some techniques to affirm human rights and to deter their infringement. As in many other

177. Id.
countries, advocates of the retarded in Sweden rely primarily on publicity, pressure group tactics, and the supervisory and regulatory powers of the semi-autonomous central state boards. They are aided by fundamental Swedish law which provides powerful curbs against secret government decisionmaking. Consumer organizations and conscientious officials use these laws to detect service deficiencies and to foster public support for remedial proposals. The central state boards, such as the National Board of Education (Skoloverstyrelsen) and the National Board of Health and Welfare (Socialstyrelsen), through their respective special education and mental retardation divisions, are vested with continuing responsibilities to monitor and upgrade services for the retarded. Recent initiatives by Parliament and the Justice Ombudsman augment protection of the rights of mentally retarded individuals.

1. Publicity

In Sweden, the advocates for the disabled make effective use of potent press and freedom of information laws. To further “free interchange of opinion and general enlightenment,” under the Freedom of the Press Act, “every Swedish citizen shall have free access to official documents.”

Subject only to narrow statutory limitations, correspondence and other official documents are available for public scrutiny as a matter of course. For instance, in complying with this “publicity principle,” the Ombudsman generally places the communications of a particular day on a table in his anteroom for members of the press to review.

Another important principle by which the friends of the mentally retarded are alerted of impending government action is known as “remiss.” This principle requires advance circulation and submission of views by all relevant agencies of government before a matter is finally considered. It offers the public a chance to learn of and react to proposed policy.

FUB (The Swedish National Association for Retarded Children) and other friends of the retarded rely strongly on the “remiss” and “publicity” principles. Civil servants, fearing exposure, may be deterred by these principles from encroaching on individual benefits and civil liberties. As one legal commentator explained, public access to government files “helps

178. The Freedom of the Press Act, ch. II, art. 1, S.F.S. 1965:818 as amended by S.F.S. 1974:155, reprinted in THE SWEDISH RIKSDAG, CONSTITUTIONAL DOCUMENTS OF SWEDEN 123 (1975). Certain narrow exceptions may be imposed out of consideration for state security or individual privacy, but the “cases in which official documents . . . are to be kept secret, shall be clearly defined in a specific act of law.” Id.

 insure that due process of law prevails in relationships between individuals and government agencies. The publicity principle exerts a pervasive preventive effect by virtue of the sobering influence of prospective public scrutiny.  

2. Private Pressure Groups

FUB maintains its credibility as the consumer’s independent lobbyist regarding retardation services. Mindful of potential conflicts of interest, FUB and its local affiliates neither own nor run direct care services (with the exception of a few recreation centers). As a result, FUB has great freedom to criticize and influence public policy and action. It has called upon the Federation of County Councils to accelerate implementation of the Provisions Act and to combat reactionary trends and statements. Perhaps FUB’s most durable legacy is its campaign for affirmative legislation. Its latest efforts produced fundamental reform of guardianship laws. Not content with paper achievements, FUB designated its director, Allan Everitt, as an organizational “ombudsman” to represent aggrieved retarded individuals. In addition, FUB identifies the benefits of effective services and the costs of defective services. FUB’s standard, based on principles of integration and normalization, is used as “a yardstick when measuring [its] achievements and [its] shortcomings.”

3. Central Regulation and Supervision

Central state agencies in Sweden have a major influence in effectuating legislation within their spheres of action. They are not considered to be a part of the ministry under whose auspices they work. Not only are they placed at some distance from political interference, but their officials enjoy considerable freedom to express their personal views in public. The mentally handicapped have been fortunate in having outspoken and activist officials to steward their affairs.

Under the Provisions Act, an unusual degree of central supervision is vested in the National Board of Health and Welfare and the National Board of Education. The National Board of Health and Welfare, for example, has the duty of approving county care plans, inspecting institutions, and licensing private facilities. Its mental retardation division sets standards

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180. *Id.* at 447.
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for day and residential facilities, promulgates detailed circulars on the
conduct of services, organizes staff training conferences, and provides other
consultative assistance. Together with the National Board of Education, it
has responsibility for overall implementation of the Provisions Act.184

Dr. Karl Grunewald, who is in charge of the mental retardation division of
the National Board of Health and Welfare, has been a major architect of
Sweden's retardation services and a catalyst for their improvement. For
example, under his guidance, the National Board has given greater attention
to the sensitive task of informing parents of a child's diagnosed mental
retardation. A multidisciplinary approach is involved from the beginning to
promote sound planning for the child's future and to assist parents in coping
with this traumatic event. Physicians are not to provide this information
alone, but are to be joined by a social worker or a psychologist familiar with
the child's problems and the services available. Another Board circular
encourages the placement of young retarded children in foster homes, and in
certain cases of unreasonable parental objection to foster care, the Board can
authorize such care in lieu of institutional placement.185

The Board's guidelines also encourage normal living patterns and auton-
omy, restrict segregation on the basis of sex, and promote counseling for
clients and their representatives. The National Board of Education has anal-
ogous regulatory powers, including the power to prescribe the content of
special education and training programs.

Other forms of centralized regulation are less frequently used. For those
under compulsory care there is a structure for formal review of decisions on
admission, leaves of absence, or discharge. These decisions committees and
the Swedish Commission on Applied Psychiatry comprise an independent, but
little used, complaint process. Furthermore, no judicial case has arisen from
this process.

C. Recent Developments in Safeguarding Human Rights

1. Reforming the Guardianship Laws

For many retarded persons, a personal advocate is indispensable in protect-
ing their human rights. For some time, FUB pointed out the limitations of
conventional guardianship laws and services.186 In addition, FUB criticized
the following: (1) an inadequate financial basis for recruiting guardians;

184. Interview with Dr. Karl Grunewald in Stockholm (Apr. 8, 1974).
185. Interview with Dr. Karl Grunewald in Dublin (Sept. 17, 1975).
186. See, e.g., A. Everitt & R. Sterner, Future Roles of the Guardian of the Mentally
(2) insufficient contact between guardians and institutionalized wards; (3) failure to provide limited forms of guardianship for those competent to vote, marry, or assume other civil rights and responsibilities; and (4) failure to ensure periodic review of the necessity for, and the effectiveness of, an individual's guardianship. Writing in 1969, Everitt and Sterner cogently argued for a new guardianship system that would stress the personal, rather than the financial aspects of care.\textsuperscript{187} In particular, they suggested the guardian play a major role in maintaining contact with wards enrolled in service programs. Even in institutions, the retarded person would be "in great need of human contacts with the 'outside,'"\textsuperscript{188}—somebody who would look out for his well-being and interests. This person could ask of service providers such questions as: Is the resident really receiving the services that suit his condition? Are those services of adequate quality?

Sweden, in 1975, adopted new legislation which reflects the above recommendations and embodies the conclusions of the 1969 ILSMH Symposium on Guardianship of the Mentally Retarded.\textsuperscript{189} Its principal feature is to permit the appointment of a trustee for persons whose impairment warrants counseling, but not plenary supervision. In such instances, a client may only need the advice of a trustee who is able to gain his confidence and "watch over his interest and well being."\textsuperscript{190} Guardianship, on the other hand, is authorized for a person over 18 years of age only when he, because of "psychic illness or abnormality or intellectual impairment," is unable to care for himself and his property, and is declared a legal minor after a judicial proceeding. Before doing so, a court must specifically find that trusteeship is not a sufficient measure to meet the person's needs. The trustee, vested with a formal status, can perform certain legal acts and is paid for services rendered. The law instructs both trustees and guardians to give first priority to "watching over personal needs," and secondary consideration to property administration.\textsuperscript{191} Furthermore, in the appointment of guardians, courts are no longer to give close relatives unquestioned priority.

Although FUB lobbied for free guardianship and trusteeship services for all in need of them, the law requires retarded individuals with a personal

\textsuperscript{187} Id.
\textsuperscript{188} Id. This need may be particularly acute when the services for the retarded are unsatisfactory, due to high turnover of personnel, to deficiencies in the vocational training of part of the staff, or to other reasons.
\textsuperscript{190} R. Sterner, Modernized Swedish Legislation on Guardianship and Trusteeship (1975) (FUB paper, Stockholm).
\textsuperscript{191} Id.
income above 20,000 Swedish crowns (approximately $5,000) or assets above 40,000 Swedish crowns (approximately $10,000) to make a contribution to the cost of such services. Below those levels, the municipality fully assumes the expenses. FUB regards this aspect of the law as unsatisfactory and incompatible with the principle that “no costs due to a handicap shall be charged to the handicapped person himself.”  

The new law does, however, provide a firm base for advocacy for retarded individuals.

2. “Activist” Ombudsman

Under one of Sweden’s fundamental laws, the Riksdag (the Diet of Sweden) appoints at least one or more ombudsmen for the purpose of supervising the “application in public service of laws and other statutes.” Appointed to four-year terms on the basis of “legal ability and outstanding integrity,” they have the political independence to “evaluate and pinpoint whether a particular department or bureaucracy is functioning properly.” Although armed with the powers of a public prosecutor, their major function is investigative rather than prosecutorial. The Justice Ombudsman has become an important ally of the mentally retarded.

As with other positions of power, the effectiveness of the Justice Ombudsman depends upon the person who holds the office. He may be either an “activist” or a “passivist,” depending upon his inclination to intervene on his own initiative. A passive ombudsman will be of little value to mentally retarded individuals, persons often least able to initiate complaints.

Bertil Wennergren, the present Justice Ombudsman, has for several years regularly inspected prisons and mental hospitals. Believing that institutions for the retarded “should not be left aside,” Ombudsman Wennergren began visiting such institutions to familiarize himself with the mental care facilities. In a two-year period, he estimated that 15 institutions for the

192. Id.
193. “Ombudsman” literally means “on behalf of man.”
194. The Swedish Riksdag, Constitutional Documents of Sweden 61 (1975) (translation of The Instrument of Government Act entered into force Jan. 1, 1975, ch. 12, art. 6). The ombudsmen have broad powers which include “access to the minutes and other documents of courts and any such authorities,” initiating legal proceedings against civil servants, requesting and obtaining information and reports from “[a]ny court or administrative authority as well as any civil servant of the State or municipality . . . ,” and obtaining the assistance of any public prosecutor. Id. at 61-62.
196. Interview with the Honorable Bertil Wennergren, a lawyer who has been Justice
mentally retarded were visited, and 40 individual complaints of retarded persons were decided. In some 5 to 10 of those cases criticism of public officials was found warranted.

The Justice Ombudsman's effectiveness rests on more than the incumbent's rhetorical power. His power to recommend change is reinforced by followup investigations. He may demand explanations for tardiness in making recommended changes and this, in turn, may result in sharp criticism of the public officials by the press. These officials may also be criminally prosecuted for breach of duty or inexcusable failure to comply with the Ombudsman's decision. However, relying on powers of persuasion, Ombuds-

Ombudsman since 1972, in Stockholm (Apr. 9, 1974). Ombudsman Wennergren further described the scope of his mental retardation activities:

On my own initiative, I visit institutions for care of such persons, and I travel around the country and try and see as many of these institutions as possible. I spend one day with each institution to make myself acquainted with what is going on—what standard an institution has, what kind of activities and therapies they use, how much personnel they have, and what kind of education the personnel has, and . . . their general capabilities of fulfilling their functions. And I talked with persons that are living in those institutions, retarded persons living in those institutions. That makes it possible for me to know what the whole thing is about, and what is going on. And that makes it easier for my second task, which is to consider the complaints from persons in those institutions or persons outside those institutions who may have applied to be taken care of in such institutions, or their relatives that complain about the treatment in those institutions, or complaints about such persons being compulsorily taken into such institutions against the will of such relatives and against the will of the person himself. So that's the broad outline of my work, to inspect as many institutions as possible, and to make myself acquainted with what is the state of the matters in the field at the local levels, and secondly to consider and investigate complaints regarding subject matters in the field of the caretaking of retarded persons.

Id.

197. Id.

198. The Ombudsman, aided by a staff of eight lawyers and professional consultants, relies in this process on his persuasive and factfinding powers. Ombudsman Wennergren described the process:

If I find there is something that you expect should be better, than I can write to the board in charge and tell them, that according to my opinion, they should improve the standard and see to it that the food should be better, persons should have better clothes, furniture, food or beds, or whatever it may be. But I have no powers to tell them that they must improve. I just say that according to my opinion that desirable improvement should be taken. Then I can later on come back and see if they have taken any measures, and if they haven't I can take it up again and ask them why haven't you done anything to improve matters? Then they have to explain it to me; then I may once again, and more strongly, tell them to take measures. . . . If I argue in a convincing way, then there should be results—although it's up to me to chose my arguments and really try and argue in as strong a way as possible.

Id.
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man Wennergren employs his prosecutorial discretion only in exceptional cases (perhaps five times yearly, none so far involving mental hygiene officials). As he points out, though, all Swedish officials “know I have this club behind my back.” Furthermore, he can, and has, brought disciplinary proceedings against state employees (including medical doctors) who exceed their authority or “neglect to perform their official duties properly.”

The Ombudsman’s investigative ambit is broad. Unlike the British Parliamentary Commissioner, the Ombudsman may start an investigation on his own initiative. Complaints may also be received directly from the public, or from any other source, including a third party acting on another’s behalf. If investigation discloses gaps in a particular statute or its application, the Ombudsman will report to Parliament and recommend changes. If some general neglect of administrative duty is suspected, the Ombudsman is empowered to conduct a full investigation with complete access to the agency’s files and personnel. Furthermore, if necessary, he can request a court to hear sworn testimony in furtherance of an investigation.

With 3100 complaints handled each year by the Ombudsman’s office, only a small fraction of his work can deal with the mentally disabled. However, the Ombudsman has become more active in the institutional and community problems of mentally retarded persons. This increase in activity can be attributed to the Ombudsman’s own institutional tours and interviews with residents and staff, and to leads from newspaper stories, retarded persons themselves, their relatives, their friends, or other concerned professionals. Of his “not so numerous” investigations into retardation services, the Ombudsman estimated that 60 percent were begun by third-party complaints, 25 percent by retarded persons themselves, and the remainder by newspaper items that came to his attention. Even with a staff of eight lawyers and consultants, however, the Ombudsman can only be a backstop to the regular machinery of supervision. Ombudsman Wennergren described some factors which inhibit complaints. Although mentally retarded residents are generally informed of his inspections and of their right to speak to him, it is uncertain how many understand what an Ombudsman is and what he can do. Those requesting an interview are seldom residents of ordinary institutions. They tend to be the court-detained inmates of special hospitals, such as the Salberga residents, who, according to Wennergren, “know quite well what an Ombudsman is.”

199. The Instrument of Government Act, ch. 12 art. 6, reprinted in CONSTITUTIONAL DOCUMENTS OF SWEDEN, supra note 194, at 61.

200. Interview with Ombudsman Wennergren in Stockholm (Apr. 9, 1974). In the past, inmates at Salberga have filed petitions with the Ombudsman, complaining of deficiencies in their treatment. Id.
An Ombudsman, however, can protect a retarded person who may be unaware of how his interests are compromised by his guardian or custodian. Ombudsman Wennergren recounted some examples of hidden conflicts which have been handled by his office, including "voluntary" admission procedures, family care placement, resident's pocket money, selection of guardians, education for hospital residents, and access to public

201. In one case, a 30-year-old mentally retarded woman was institutionalized by a court. On the basis of a doctor's testimony that proceedings were warranted and that the woman should not be heard in court, the court approved the guardianship application without an appearance by the woman or her relatives. Although they claimed that no notice of the hearing had been received, the woman and her relatives had probably received, but had not understood the formal notice. The Ombudsman severely criticized this "voluntary" institutionalization. He determined that no real consent had been obtained, that admission had taken place under a deception that the woman's brother was taking her to see a doctor for a physical ailment, and that the retarded woman had locked herself in a room to resist institutional admission and had been taken forcibly to the hospital. The investigation, which included the Ombudsman's own one-hour interview with the woman in an institution, in the Ombudsman's words, "gave me cause for severe criticism of the official of the Mental Retardation Board who had relied on the custodian's [brother's] report of what the woman had said and what had passed." In such cases, the Ombudsman held that a valid consent must be documented in the files and be founded upon a personal interview with the person in question. Id.

202. Through a newspaper story, the Ombudsman became aware of a mentally retarded woman who had been placed in an exploitative family care home. In this private home, the woman was alleged to have received poor treatment, such as a cellar bedroom, long hours of work, little free time, and no permission to see her boyfriend. Upon investigation the Ombudsman found that the Mental Retardation Board responsible for supervising her family care had failed to fulfill its statutory duty to conduct four inspections of the home per year. While conditions in this particular home were not as bad as reported, the Ombudsman felt that deficiencies in her treatment "should have been observed by the controlling official from the board, but he had neglected his duty of inspection, and she had been left without the support to which she was entitled." Id.

203. After a published newspaper article based on the Board of Health and Welfare's inspection of a Gothenburg institution, the Ombudsman launched an investigation of guidelines regarding the payment of reduced pensions to retarded persons living in institutions. On the basis of this investigation, the Ombudsman suggested that the guidelines and directives should provide that residents are to receive a minimum of 300 kroners per year, and that any reduction in the amount of their pension payments should be based on an individual determination of whether any reduction is warranted. According to Ombudsman Wennergren, "what they [the administrators] had neglected and not understood in Gothenburg was that they could differentiate. They had in all cases deducted down to the bottom and had not used their discretion." Id.

204. A mentally retarded woman was thought to be vulnerable to fraud by her brother in the distribution of their father's estate. To prevent this, the Mental Retardation Board asked a court to place the woman under the guardianship of Mr. Allen Everitt of FUB. The brother, however, objected to the appointment and succeeded in having his wife appointed as guardian. Afterward, the retarded woman lost quite a lot of money and other property. A complaint was filed, which, in the Ombudsman's view, posed the following issues: "What should the board do in such a case . . . and were they obliged to give her any services here?
buildings.\textsuperscript{205}

Identifying and filling legislative gaps is one of the distinctive roles of the Swedish Ombudsman. Ombudsman interpretations of statutes and case law, when founded on "good factual and legal reasoning," can constitute persuasive opinions of law.\textsuperscript{206} Beyond their precedental impact, however, these opinions are potent vehicles for ventilating injustices, small or large.

The advocate and the Ombudsman can perform complementary functions. While the Ombudsman deals with the exceptional case as a nonpartisan, the advocate owes his allegiance to his client and his client's day-to-day interests. Through his work with the retarded, Ombudsman Wennergren strongly endorses the need for volunteer and professional advocacy. He believes that if the retarded individual is to make effective use of society's remedial machinery, the advocate should be based at one facility so he is a familiar figure to his clients.\textsuperscript{207} Even a retarded person who knows how and where to make a complaint to the Ombudsman can benefit from advocacy because for many retarded persons the filing of a complaint is a "threshold...that they may not be able to climb."\textsuperscript{208} The Swedish Ombudsman, however, has attempted to lower that threshold for the mentally disabled.

\textbf{D. Implementation of the United Nations Declaration}

Swedes candidly assessed the distance between international standards and their national laws, and between law in the books and law in practice. Allen Everitt, Executive Director of the Swedish National Association for Mentally Retarded Children (FUB) compared Swedish law and practice to the principles of the United Nations 1971 Declaration on the Rights of Mentally Re-
While not officially incorporated in domestic law, the declaration, Everitt stated, is in large part "fulfilled in [Swedish] law, if not in the practical light."210

1. Article I: Equal Rights

Equality of rights for the retarded is rated by Everitt as excellent in law and good in actual fact. "In law," according to Everitt, "the mentally retarded person has the same rights as others and also has the right to special treatment that he may need because of his handicap." In practice, however, perfect equality does not exist. For instance, the retarded person loses his right to vote if he is institutionalized. FUB opposes this situation on the grounds that everyone who can vote should have the right to do so. With respect to marriage, Swedish legislation no longer imposes any general impediments to the marriage of retarded persons. Under the 1973 family law reform,211 the retarded, mentally ill, or epileptic person has a right to marry providing he or she understands the legal implications of marriage. While a ward must have the consent of his or her guardian in order to marry, a court can now overturn an unreasonable refusal.

2. Article II: Developmental Services

Access to developmental services is rated excellent in law and good in practice. The retarded person, by law, has the right to education, training, guidance, and rehabilitation. Under section 2 of the 1967 Act on Provisions for Certain Mentally Retarded Persons, county councils must "provide the mentally retarded residing within the county with education, care and other services made mandatory by this law, in so far as someone else does not provide for it." Some retarded persons, however, still encounter difficulties in gaining admission to ordinary hospitals to receive the medical care to which they are legally entitled.212

3. Article III: Economic Security Work

Economic security and work opportunities in Sweden are considered excellent in both law and fact. Adequate pensions and rent monies are available

209. Interview with Allen Everitt in Stockholm (Apr. 9, 1974).
210. Id.
211. Prior to this reform, Sweden had a law which, although infrequently utilized, permitted a mentally disordered person to be sterilized on the basis of certificates from two doctors (the doctors had to have been approved by the National Board of Health and Welfare). Involuntary sterilizations are now prohibited. Act on Sterilization of June 12, 1975, S.F.S. 1975:580.
212. Interview with Allen Everitt in Stockholm (Apr. 9, 1974).
to retarded persons incapable of supporting themselves. Set at 105 percent of a fixed living standard (in 1974, 8500 Swedish Crowns, approximately $2100), pensions are periodically increased. Even those in residential institutions receive pocket money. In addition, under section 4 of the Provisions Act, each county must provide vocational training and day centers for work opportunities. Productive work is compensated.\(^{213}\)

4. Article IV: Home and Community Life

The quality of retarded Swedes' home and community life is rated excellent in law and varies from very good to unsatisfactory in practice.\(^{214}\) Section 4 of the Provisions Act establishes as the preferred alternative, care for retarded people in their own homes. However, the quality of home care assistance is often insufficient, especially in sparsely populated areas where visits by speech and physical therapists, social workers, and other professionals are infrequent and sporadic.\(^{215}\)

5. Article V: Guardians

Guardianship services were previously deemed unsatisfactory in both law and fact.\(^{216}\) However, the Swedish guardianship law was recently altered to adopt certain FUB proposals. Those proposals urged guardianship services paid by the community, visitation of persons in institutions (with all visiting expenses and fees reimbursed), and elimination of automatic preference for relatives as guardians. FUB made clear that most retarded people do not need a guardian, but could be helped by a lay advocate without consequent loss of rights. With the substantial adoption of these proposals, it can be said that guardianship services are excellent in law. A judgment on the practical effect of this law, however, must await further observation since it only took effect in January 1976.

\(^{213}\) Id.

\(^{214}\) Mr. Everitt elaborated:

Many care homes are good, but also we have care homes and special hospitals which are not very good. If you go to Salberga, you will see a hospital which is too big, old buildings, new buildings too, but not very good. Most counties have good services, but two or three counties, such as Stockholm county, have big institutions and unsatisfactory services.

\(^{215}\) Id.

\(^{216}\) Id. Mr. Everitt observed: "We think that the advocates could be useful for that [improving home care assistance for residents without family ties]. In Lund, we are trying this with a local parents' association interested in these questions, and have started a small scale citizen advocacy project with ten advocates regularly visiting children in mental retardation institutions." Id.
6. Article VI: Legal Protection

Legal protection for the retarded was rated good in law and practice. However, the language of article VI is so broad\(^2\)\(^17\) that Everitt expressed uncertainty as to its application. If “abuse or exploitation” refers to physical maltreatment, then general criminal law was seen as sufficient. However, discrimination may take the form of degrading treatment for which remedies are not as apparent (for example, retarded people being unwelcome in restaurants or as neighbors in day centers or hostels). Other discrimination may spring from benevolent intentions. In these kinds of discrimination, Swedish legal protection was considered inadequate in law and in fact.

7. Article VII: Procedural Safeguards

Incompetency proceedings formerly considered unsatisfactory, have been changed by the new law on guardianship and trusteeship. Incompetency proceedings under the old law had drawn the Ombudsman’s criticism for defects in the notice to and right of appearance of the mentally retarded person under consideration. No longer can incompetency be determined solely by psychiatric diagnosis and without periodic review.

E. Summary

By securing the “concrete rights of the handicapped in mandatory Acts of Law,” Sweden has realized great advances for the mentally impaired.\(^2\)\(^18\) But the Provisions Act of 1967 does not by itself establish minimum enforcement powers, or quality standards, or time frames for compliance. To keep the promises of a welfare state, someone must be watchful that no mentally retarded person is denied his full value as a human being.

A vigilant Ombudsman, National Board of Health and Welfare, and consumer’s association all contribute to that task. Last year, legislation to meet the retarded individual’s need for advocacy, representation, and personal guidance went into effect. In collaboration with public officials, FUB is recruiting new trustees and guardians, instructing them in their duties, and preparing manuals on the rights of the retarded.

Sweden’s recent reforms again demonstrate the importance of international exchange and collaboration. Out of the International League of Societies for the Mentally Handicapped and the United Nations Declaration on the Rights of Mentally Retarded Persons, Swedish leaders acknowledge sources

\(^{217}\) See note 58 supra.
\(^{218}\) K. GRUNEWALD, supra note 22, at 1.
of inspiration and support for domestic reform. In the words of that remarkable champion of the disabled, Dr. Richard Sterner,

[t]his international documentation, discussion and development, indicating a consensus among parents and legal and other experts concerned with the matter in many countries, has made it easier for us to develop our ideas and to present the arguments for reform in an authoritative and convincing manner.219

IV. GREAT BRITAIN: THE STRUGGLES AHEAD

A. The Case for Human Rights Protection

In 1969, the British public "discovered" anew the "ill treatment of patients and other irregularities" in institutions for the long term care of the mentally retarded.220 An inquiry headed by Sir Geoffrey Howe found that "lax and old-fashioned standards of nursing" contributed to mistreatment of "mentally sub-normal patients."221 Thus began, in the words of a leading British specialist, "a period of great disquiet" about services for the mentally handicapped in the United Kingdom.222 That disquiet has been fueled by other committees of inquiry and unofficial reports and studies.223 In response, calls for reform have poured over from newspapers224 and voluntary associations225 to courtrooms226 and governmental committees.227

219. R. Sterner, supra note 190, at 4.


221. ELY REPORT, supra note 220, at 123.


223. See, e.g., DEP'T OF HEALTH & SOCIAL SECURITY, REPORT OF THE COMMITTEE OF INQUIRY INTO SOUTH OCKENDEN HOSPITAL (1974). The South Ockenden Report, for example, described prolonged solitary confinement "completely lacking in dignity and incapable of justification." Id. at 50. For a list of other official inquiries, see note 234 infra. For studies which compile the unhappy facts, see K. JONES, supra note 22; P. MORRIS, PUT AWAY: A SOCIOLOGICAL STUDY OF INSTITUTIONS FOR THE MENTALLY RETARDED (1969).


225. For example, on May 14, 1975, the Campaign for the Mentally Handicapped held a full-day workshop at London University on the rights of the mentally handicapped. Speakers, including Professor Gunnar Dybwad, Ann Shearer, and the author, discussed actions parents could take to vindicate the handicapped person's rights to edu-
An underlying issue of this concern is whether or not the existing British law adequately protects the fundamental rights of the retarded.

1. The Setting

Responsibility for services for the mentally handicapped in Britain is bifurcated. While residential services are primarily a central government responsibility, other services are provided primarily by local jurisdictions. The National Health Service, through specialist hospitals and central funds, provides hospital accommodations for some 64,000 retarded persons. Local education authorities and social service departments, funded from local property taxes and central government grants, offer educational and training facilities and some 7,000 residential places in hostels and other small living units.228 The range and quality of these services vary enormously among geographic localities. Although there are policy guidelines from the central government, according to a British Medical Research Council scientist, they "have not been followed closely."229 The result is highly variable patterns of care.

In 1971, a government policy paper attempted to correct imbalances between hospital and community care.230 However, blueprints alone did not dislodge entrenched medical models or offset the bias toward hospital-centered care.231 National policy, like national legislation, failed to specify...
how and when multidisciplinary habilitation services would be delivered. Instead, it left in place a pattern of divided responsibilities with little coordination between the educational, health, and welfare services for the retarded.

A survey of English mental subnormality hospitals by Pauline Morris showed that many residents were housed in remote facilities under custodial regimes. This pattern of residential inactivity was confirmed by a Department of Health and Social Security census which found that, of 64,000 residents, 59 percent were receiving no education or training. Coupled with serious overcrowding and staff shortages in many hospitals, residents faced risks of deterioration and abuse. Evidence of these hazards were set out in full-scale committee of inquiry reports. Mrs. Barbara Castle, then Secretary of State for Social Services, stated that the government, not individual care workers, was primarily responsible for substandard conditions and that improvements in care and management would be impossible until institutions for the mentally handicapped were allocated "a fair share of resources."

Two other serious problems were noted in Mrs. Castle's critique of English mental retardation care. Difficulties were found in getting staff to learn and apply new techniques and practices, particularly with violent or difficult residents; and hospital staff and management were perceived as tending to close ranks against criticism or complaints on behalf of patients, thereby hindering action on justifiable complaints. While the South Ockenden Hospital inquiry focused on misuse of seclusion, unexplained physical injuries (resulting in the death of one patient), and the breakdown in internal machinery for acting upon well-founded complaints, the most poignant statement on why things went wrong at this hospital was in a letter reprinted in the official report, but written some five years beforehand.

Criticism should be directed less at individuals who have had to work at South Ockenden under very difficult conditions, or at those who have had to try to deal directly with the problems arising from these conditions, than at successive Governments who have failed to ensure that NHS authorities devoted adequate resources to hospitals for the mentally handicapped.

Mrs. Castle also noted in the report, however, that progress had been made since 1969: per patient expenditures increased by 60 percent; nurse staffing increased by one-third; and overcrowding decreased by one-third. Id.

The letter stated:

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232. See P. Morris, supra note 223.
234. See, e.g., DHSS, REPORT OF THE COMMITTEE OF INQUIRY INTO SOUTH OCKENDEN HOSPITAL (1974); DHSS, REPORT OF THE FARLEIGH HOSPITAL COMMITTEE OF INQUIRY, CMND. NO. 4557 (1971); ELY REPORT, supra note 220.
236. See id., at 183-84. The letter stated:
hospital's medical staff called 'attention to the serious hazards of patient overcrowding, which was seen as destructive of the rights of residents. Through public inquiries and the work of tough-minded journalists, parents, and friends of the retarded, the comforting images which mask the work yet to be done are slowly being pulled away.

2. Protections in Law

In 1959, Parliament took a large step toward classifying mental retardation as a medical problem and removing any legal checks on care and custody by promulgating the Mental Health Act,\textsuperscript{237} which substituted medical for judicial authority in mental hospital admissions. In passing the Act, Parliament stripped magistrates and county court judges of their reviewing powers, abolished the board of control with its regulatory and supervisory responsibilities over mental institutions, and placed the criteria for admission to mental hospitals largely under medical discretion. Legal regulation of admissions and other aspects of mental retardation care diminished in all dimensions. The Act accomplished this in three principal ways: broad and vague detention standards; informal admissions without statutory criteria or safeguards, and abolition of any prior or independent review of compulsory admission decisions.

In Great Britain, however, there is no single law authorizing or coordinating special services for the mentally retarded. Education and mental health laws differ strikingly in terminology, definitions, and diagnostic procedures for ascertaining eligible retarded clientele. Under the Mental Health Act, the terms "subnormality" and "severe subnormality" are defined as subcategories of mental disorder.\textsuperscript{238} These terms are woefully obsolescent and stigmatizing. Moreover, they are defined in vague and metaphoric language. "Subnormality" is defined as a "state of arrested or incomplete development of

\footnotesize{Overcrowding appears to us to be the key factor in the viciously spiralling process of falling standards of patient care. . . . All patients have a right to have their talents and abilities exercised to the full. The responsibility for seeing that this is done and that each individual patient's potential is realized as completely as possible rests with us who are in charge of their care. We believe that no training programme can succeed in the long term if the present degree of overcrowding is allowed to continue, nor can we compete successfully with other hospital groups or other specialities in terms of standards of patient care.}

\footnotesize{237. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72. For elaboration and documentation of the material discussed in this section of the article, see S. Herr, Beyond Commitment: Remedies for Maltreatment (1975) (chapter in unpublished doctoral thesis, on file with the Interdepartmental Committee to Review the Mental Health Act, Dep't of Health and Social Security (DHSS), London).}

\footnotesize{238. Mental Health Act, 1959, §§ 4(2)-(3).}
In its severe form, it is defined as an incapacity for independent living; in its mild form, as being susceptible to or requiring medical treatment or other special care or training. Given regional, professional, and idiosyncratic differences in diagnoses, these broad labels do not clearly demarcate the range of persons covered under the Act's compulsory and other provisions.

Under the Education Act of 1944 and its implementing regulations, children and young persons who require special education by virtue of limited intelligence are termed "educationally subnormal" or "severely educationally subnormal." While these terms are no less ambiguous and denigrating than those used in the Mental Health Act, a 1975 Department of Education circular narrowed the medical role and clarified multidisciplinary responsibilities for diagnosing and placing these children.

These dual statutory strands of outdated terminology give rise to confusion. In part, the public and the professionals resolve this by entirely bypassing both sets of terms. Instead, the terms in current general use are "severe mental handicap" and "mental handicap." They have, however, no statutory meaning or clearly understood limits; to some, they connote emotional disorders as well. Future statutes may better define eligibility for services on the basis of special behaviorally described needs rather than on the basis of labeling people mentally defective. If some label is then still desired to describe the general focus of those services and needs, "mental retardation" has the virtue of international usage.

Difficulties in existing English law, however, are more than semantic. In the past, the Mental Health Act has been viewed as the most important act dealing with the mentally retarded. At present, it is a mere shell. Amendments, such as the Education (Handicapped Children) Act of 1970, the Health Services and Public Health Act of 1968, and the Nursing Homes Act of 1975, have gutted and largely repealed the 1959 Mental Health Act's local services provisions. The repealed sections, however, remain in reprinted copies of the Act without citation to replacement provisions, thereby confusing practitioner and public alike. Furthermore, with reorganizations of social services and health care, those with protective roles under the 1959

239. Id. § 4(1).
240. Id. §§ 4(2)-(3).
241. 7 & 8 Geo. 6, c. 31.
243. C. 52, § 2(2) and sched.
244. Id., c. 46, sched. 4.
245. Id., c. 37, sched. 3.
statute, such as the mental welfare officer and the managers, may have been assigned other duties. Most importantly, the assumptions underlying the Mental Health Act are out of step with the scientific knowledge and professional challenges now accepted in the retardation field.

The Royal Commission on Mental Illness and Mental Deficiency,246 which met from 1954 to 1957, was persuaded by what might be called an “ideology of sickness.” In organizing the statutory services for the “mentally subnormal,” the Commission took as its premise that such people were to be dealt with as a subclass of sick persons. The adoption of this medical model had decisive implications. Sick people are commonly thought of as requiring doctors, not educators or social workers. They are thought to need cures, not rights. Since only doctors know how to “cure” and command technologies which laymen do not grasp, laws must not interfere with the curing process. Moreover, with curative treatment seen as sophisticated and complex, medical practitioners demanded and received uninhibited “clinical freedom” in regard to hospitalized mental patients. The mentally subnormal, thus categorized as patients requiring “medical treatment . . . and . . . care and training under medical supervision,”247 could be treated as if permanently sick.

These assumptions are at the core of some human rights and service delivery problems affecting the mentally retarded in Britain. In 1975, a fuller exposition of those problems and their legal ramifications was placed before the Interdepartmental Committee on Review of the Mental Health Act. In 1976, the committee issued a consultative document which acknowledged, but did not resolve the following question:

The question whether mental handicap per se should be retained within the scope of mental health legislation at all has not been raised by the Butler Committee, the Royal College of Psychiatrists, MIND [National Association for Mental Health], or BASW [British Association of Social Workers] but may be thought to deserve consideration. It is however a question which raises far wider issues than are within the scope of this Chapter. . . . Comments would be appreciated on how the respective interests of mentally handicapped people and the general public might best be served in this connection.248

247. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72, §§ 4(3), 147(1).
B. Access to Residential Treatment

Residential services for the retarded in Britain consist primarily of hospital services. It is a "matter of historical accident," according to James Elliot of the King's Fund, that Britain's institutions for the mentally retarded are designated as hospitals and placed in the National Health Service (NHS).\(^\text{249}\) Unfortunately, it is an accident which acquired the patina of legislative respectability and the momentum of vested interest. Given the current funding pattern, the government's targets for small family-like group homes and supporting services for families are not met. Despite improvements, the National Society for Mentally Handicapped Children remains skeptical that local authorities will assume the burden of providing much of this care without additional financial incentives.\(^\text{250}\)

Funding, however, is only part of the implementation difficulties. A good mental retardation service requires the ongoing collaboration and coordination of a number of disparate professions. The Mental Health Act provides no mechanism for that collaboration or for the meshing of NHS and local services. Indeed, the Act is part of a legislative pattern which divides officials and professionals among three public services: The NHS, local education authorities, and social service departments.

As noted above, the Royal Commission on Mental Illness and Mental Deficiency contributed to medical primacy in the mental retardation field. In fact, the Commission's report began with the categorical statement that "[d]isorders of the mind are illnesses which need medical treatment."\(^\text{251}\) Under the rubric of mental disorder, the Commission lumped together all persons of subaverage intelligence. It was then logical for the Commission to choose a single set of legal principles for dealing with mental disability and mental illness. It also decided that the treatment of mental illness should be placed on the same footing as physical illness. The Commission therefore concluded that special legislation was not required to "maintain standards of care for the mentally ill or disabled."\(^\text{252}\)

Parliament concurred and made no particular provisions for inspections or quality controls of mental disability facilities. The principle of "parity with physical illness," however, was not consistently followed. For unlike the physically ill, the mentally disordered could be liable to: (1) compulsory admission for observation;\(^\text{253}\) (2) compulsory admission for treatment;\(^\text{254}\) (3)
forced treatment and control;\textsuperscript{255} (4) compulsory guardianship;\textsuperscript{256} (5) restrictions on incoming and outgoing mail;\textsuperscript{257} (6) leaves of absence subject to conditions;\textsuperscript{258} (7) restrictions on discharge;\textsuperscript{259} (8) restrictions on managing property and personal affairs;\textsuperscript{260} (9) prohibitions on sexual intercourse;\textsuperscript{261} (10) withholding of pay and pensions;\textsuperscript{262} and (11) impediments to initiating judicial proceedings.\textsuperscript{263}

While the Mental Health Act singled out the mentally disordered for many restrictions, it promised them few rights. For example, the Act is silent on the topic of the mentally disordered person's right to receive proper or reasonable treatment. That treatment was even intended can only be inferred from various definitional and purpose clauses.\textsuperscript{264} The Mental Health Act's preamble proclaimed that it made "fresh provision with respect to the treatment and care" of the mentally disordered, yet the Act barely addressed those subjects. Rather, it expanded the realm of implied medical authority and clinical autonomy. In the "responsible medical officer"\textsuperscript{265} it effectively vested an unshared power to direct not only clinical, but social, administrative, and educational aspects of a mentally handicapped person's life.

\textsuperscript{255} Id. \textsuperscript{26}(2). For a discussion of the controversy on the medical power to order compulsory treatment see Jacob, \textit{The Right of the Mental Patient to His Psychosis}, 39 Mod. L. Rev. 17 (1976).

\textsuperscript{256} \textit{Mental Health Act, 1959}, §§ 33-34.

\textsuperscript{257} \textit{Id.} §§ 36, 134.

\textsuperscript{258} \textit{Id.} § 39.

\textsuperscript{259} \textit{Id.} §§ 47-48.

\textsuperscript{260} \textit{Id.} §§ 101-03.

\textsuperscript{261} \textit{Id.} § 127.

\textsuperscript{262} \textit{Id.} § 138.

\textsuperscript{263} \textit{Id.} § 141.

\textsuperscript{264} See, e.g., \textit{Id.} § 1 ("this Act shall have effect . . . with respect to the reception, care and treatment of mentally disordered patients . . ."); \textit{Id.} § 4 (""psychopathic disorder' means a persistent disorder or disability . . . which . . . requires or is susceptible to medical treatment."); \textit{Id.} § 5(1) (informal admission to any hospital or mental nursing home authorized for "a patient who requires treatment for mental disorder")

\textsuperscript{265} The "responsible medical officer" is defined as the "medical practitioner in charge of the treatment of the patient." \textit{Id.} § 59. The Act is silent on the matter of multidisciplinary responsibilities for the care and treatment of the mentally disordered person. Mental health review tribunals can determine only whether a patient should continue to be detained, notwithstanding other problems which come to their attention. One chairman noted that "the Medical Members of my Tribunal frequently advise me that they are dissatisfied with the treatment afforded to patients." Letter from James A. Cooke, chairman of the Mental Health Review Tribunal for South West Thames Regional Health Authority area, to Tony Smythe, Director of the National Association for Mental Health (Oct. 21, 1974).
Parliament directed local authorities to create community alternatives. As previously noted, the central government never backed up this direction with funding for, or standards concerning, the quantitative or qualitative adequacy of hostels, group homes, or domiciliary assistance. Notwithstanding the stigma, discomforts, restraints, and diagnostic uncertainties which inhere in compulsory care, the Act insulated the admissions decision from independent administrative review. Rather than reviewing those decisions, the Mental Health Review Tribunal was limited to deciding whether continued detention was warranted. But the relevant criteria, conditions, and information at the time of possible discharge are quite distinct from those at the time of admission. The 1957 Royal Commission report to Parliament defined an acceptable admissions procedure as ensuring that each patient's individual needs are considered in the light of contemporary medical and social methods of treatment, that the form of care which he is being compelled to accept is the sort of care he really needs, that care could not equally well be provided without using compulsory powers, and that any other conditions laid down by the law are fulfilled.

Existing law and practice fall short of this exacting test. A review of the knowledge now available lends ample reason to believe that subnormality of intelligence per se is not a condition for which one should be detained.

C. Access to Education

British legislation requires education for even the most handicapped


268. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72, § 123. As one Tribunal Chairman explained, "there is now and will always be a substantial number of patients who are either detained against their will or who are incapable of leading an existence outside the hospital and whose civil rights are not at present adequately protected." Letter from James A. Cooke to Tony Smythe (Oct. 21, 1974).

child. Until 1971, severely retarded children were exempted from schooling and placed in training centers or institutions to be provided with “training . . . in lieu of education.” The Education (Handicapped Children) Act of 1970 repealed those provisions and abolished the classification of some children as “unsuitable for education at school.” In 1974, similar legislative reforms were passed for Scotland.

Local educational authorities (LEA’s) now have the duty to provide all children with programs of education. LEA’s assumed responsibility for programs in hospitals and day centers formerly conducted by the health authorities.

While special education enrollments have increased, some children are still without schooling. Furthermore, children in schools inside hospitals are often taught by a less qualified staff for fewer hours, and in more restricted settings, than their counterparts at home. In the community, the availability of programs still hinges on the vagaries of uneven LEA plans and intentions.

The 1970 legislation, sound in fundamental principle, suffered from numerous gaps. While administrative responsibilities were shifted, the Education (Handicapped Children) Act added no new minimum standards, safeguards, or funds. It simply removed an impediment to education access for the severely mentally handicapped. This change has been of value to the majority of mentally handicapped children. They can now attend community schools and they have teachers rather than nurses to carry out educational programs. Educational services are offered without charge. No tuition fee may be charged at any school maintained by a local educational authority, including any special school under the Education Act of 1944.

271. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72, §§ 11-13. See also Second Schedule of the Act.
272. Education (for Handicapped Children) Act, §§ 1, 2.
274. The Government’s “latest figures available” revealed that only 62 percent of mentally handicapped children in hospitals who were under 16 years of age and 53 percent of those under 19 were attending education programs. DHSS, FACILITIES AND SERVICES OF MENTAL ILLNESS AND MENTAL HANDICAP HOSPITALS IN ENGLAND AND WALES 30 (H.S.M.O. 1973).
275. P. Cummings, Education and the Severely Handicapped Child (National Society for Mentally Handicapped Children, Monograph No. 6, 1973); Interview with Dr. John Wilks at Pembroke College, Oxford (June 22, 1976).
277. Education Act, 1944, 7 & 8 Geo. 6, c. 31, § 61(1). If a child’s educational
Under this Act, the LEA assumes the full costs of the child’s boarding accommodations at nonpublic schools when provision of board and lodging is necessary to enable him to receive the required special educational treatment.  

The Education Act of 1944 was adopted when mentally handicapped children were still deemed “ineducable.” In many respects, it is seriously out of phase with new expectations for these children. Under the Act, for example, ascertainment of children requiring special education turns on medical examination.  

Notwithstanding the year-round needs of institutionalized children, schools on hospital grounds follow the regular school year calendar.  

Statutory procedures for determining who needs special education are unclear and outdated. Under section 34 of the 1944 Act, every local education authority has a duty to “ascertain” which children in its area need “special educational treatment.” Once having ascertained that need, the LEA has a duty to provide such treatment for the child. Treatment is interpreted to mean education by special methods appropriate to the particular disability the child suffers. Before the 1970 amendment, ascertainment had a different purpose: selection of children deemed to be ineducable from those deemed educable by special methods. On its own initiative or at a parent’s reasonable request, the education authority may cause a child over the age of two to be submitted to medical examination. Under the statutory scheme, that examination determined whether the child suffered from any disability, the nature and extent of any such disability, and the need for special education. The examining medical officer could then
issue a certificate recording these findings. On the basis of the medical officer's advice and information obtained from teachers and others, the LEA then decided whether or not the child needed special educational treatment. Unless the parent made suitable arrangements privately, the LEA would be under a duty to provide the special treatment.

Formal procedures do not reflect current roles and conflicts. Under the 1944 Act, a parent could appeal the issuance of a certificate and oppose his child's attendance at a special school. A successful appeal resulted in cancelling the certificate. It did not secure some more suitable alternative. Appeal procedures were designed for those who opposed their child's special educational treatment, not for those who unavailingly sought it. Formal procedures, as in the Mental Health Act, have been bypassed and are now less frequently applied, but the gap between statute and informal practices provokes "uncertainties and confusion." Although the Department of Education and Science (DES) concedes doctors are making what are "really educational judgments," local education authorities still rely heavily on the school doctor to classify children as educationally subnormal and in need of special education. In Circular 2/75, DES has attempted a more rational allocation of responsibilities:

The recommendation whether a child needs special educational treatment, and if so where it can best be provided, is primarily an educational matter rather than a medical one. It is therefore more appropriate that an experienced educational psychologist or adviser in special education should, after seeing the child, after considering the evidence and after consultation with medical or other professional staff concerned, assume responsibility for conveying to the authority a recommendation about the nature of the special education required and where it should be required.

With its gaps and false emphasis, the 1944 Act perpetuates a misleading view of the process of determining and reviewing who needs special education. Amended legislation, not a circular, is needed to harmonize the stages of discovery, diagnosis, assessment, and placement which determine where a mentally handicapped person lives and goes to school.

D. Access to Independent Review

Human rights protections are hindered by procedural as well as substantive uncertainties. Can a mentally retarded person enforce his right to
education or to other affirmative treatment? Can educational exclusions, based on no formal procedure or legal authority, be contested? Can grossly inappropriate placements, such as that of a Down's Syndrome child with an 85 I.Q. put in a school for the severely retarded, be appealed? Who has jurisdiction to hear these complaints: the Parliamentary Commissioner? the Health Services Commissioner? the Local Authority Commissioner? the statutory tribunals? official inquiries? Ministers? area boards? the courts?

1. The Davies Committee Report: Framework or Fragment?

In Britain, as in other countries, some would deny that maltreatment of the retarded can and does occur. The Report of the Committee on Hospital Complaints Procedure attempted a greater note of realism. Chaired by

286. Under earlier legislation, the courts sometimes did decide questions of access to education. See, e.g., Rex v. Boycott, ex parte Keasley [1939] 2 K.B. 651 (medical certificates determining an 11-year-old-boy ineducable and an imbecile quashed); Guardian of the Poor of Gateshead Union v. Durham County Council [1918] 1 Ch. 146 (C.A.) (statutory duty of local education authority to provide free education to boarded-out dependent children).

287. Complaints of this nature have frequently been brought to the attention of the National Association for Mental Health (MIND) and other voluntary associations. Interview with Tony Smythe, Executive Director, MIND, in London (Mar. 25, 1974). MIND's Legal and Welfare Rights Service has now lodged a formal complaint under the Education Act, 1944, § 99, concerning a 14-year-old who, in September 1971, was excluded from school "pending professional advice." At that time he was deemed educationally subnormal by a school medical officer. It is alleged that his exclusion was unbroken, except for approximately 24 hours of individual instruction and two weeks of residential training. Letter from Larry Gostin and Ron Lacey to the Rt. Hon. F.W. Mulley, Secretary of State for Education and Science (Jan. 21, 1976) (In re Dwight F.). Without controverting the circumstances or duration of the exclusion, the Department of Education and Science (DES) replied that the Northamptonshire Local Education Authority and various officials "have been showing diligence in seeking to provide a suitable education for Dwight." Letter from M.J. Rabarts, DES, to Larry Gostin, Ref. No. SS928 12/03, (Mar. 1, 1976) (on file at the Catholic University Law Review). Legal proceedings are under consideration. Interview with Paul Wolff, Solicitor for Dwight F., in London (June 1, 1976).

288. This actual example of misclassification was mentioned by a member of the National Development Group on Mental Handicap. Speech by Dr. G.B. Simon, Castle Priory College, Wallingford (May 8, 1975).

289. DHSS, REPORT OF THE COMMITTEE ON HOSPITAL COMPLAINTS PROCEDURE (1973) [hereinafter cited as DAVIES REPORT]. For consultation documents reflecting the Secretary of State's broad acceptance of the Davies Report, see DHSS, Draft Circular on Health Service Complaints Procedure (1976) (on file at the Catholic University Law Review) [hereinafter cited as Draft Circular]; N.H.S. Code of Practice for Handling Suggestions and Complaints (consultation draft, June, 1976) (on file at the Catholic University Law Review). The Code of Practice does, however, delete information advising patients on how to make a suggestion or complaint (leaving this to regional health
Judge Sir Michael Davies, this Committee had a broad remit from the Department of Health and Social Security:

To provide the hospital service with practical guidance in the form of a code of principles and practice for recording and investigating matters affecting patients which go wrong in hospitals; for receiving complaints or suggestions by patients, staff, or others about such matters; and for communicating the results of investigations; and to make recommendations.280

To provide “a clear and detailed statement of principles and procedures,” rather than “woolly generalities and exhortations,”291 the committee produced 24 pages of code, 11 pages of appendices, and 106 pages of accompanying report. Without belittling the project’s value, the Code has its share of “woolliness.” Nonetheless, the Davies Report has pointed out very important problems in protecting National Health Service hospital patients generally and long stay patients particularly.

The burdens of making a complaint system work, as the Committee commendably has recognized, should not fall wholly on the individual patient. The Report stated that “patients who are unable to look after their own interests also need the active support of external checks and safeguards—as well as vigilant management, particularly at regional level—to keep under review the services provided for them and to make sure that the complaints procedure is fully used when necessary.”292 The Davies Committee acknowledged the risks of victimization of staff or patients who complain and suggested remedial steps. Their critique of existing complaint channels—that they are largely internal and lacking procedural uniformity—is well founded. But the Committee’s proposed remedy seems scarcely proportionate to the problem.

Airing the patients’ complaints, the report suggests, will result in things being “set right.” To see that those complaints surface, the Davies Committee made two recommendations: the introduction of the “record book” and the creation of “investigating panels.”293 All complaints which cannot be

authorities). Id. § 2.4. The Draft Circular defers decision on the recommended Investigating Panels, noting the “danger of possible overlapping of functions between the Panels and the Health Service Commissioners, and consequent confusion to the ‘Public.’” Draft Circular at 1.

290. DAVIES REPORT, supra note 289, ¶ 1.1, at 3.

291. Id. ¶ 1.7, at 4.

292. Id. ¶ 1.12, at 5.

293. Id. ¶¶ 8.15-29, at 51-56. An Investigating Panel is seen as an independent, standing panel, composed of a legally qualified chairman and lay and professionally qualified members. It would assist in the investigation of any complaint dealing with doctors or others which could not be the subject of litigation.
satisfied by an on-the-spot explanation have to be entered in the record book. "Untoward occurrences" affecting patients must also be reported by staff, whether or not a complaint has been made. Somewhat naively, the Committee calls upon staff to record every incident in which a patient, by appearance or allegation, may have "sustained injury at the hands of another person; suffered loss or damage to his personal property, been deprived of treatment or care, food, comfort, or any other benefit to which he is entitled; been victimized in any way; or suffered any other damage to his rights, property or person." If staff are to be accusers, then investigating panels, commissioned by hospital authorities, are to be juries. As a fact-finding and recommending body, the panel would hear a limited category of those complaints unsatisfied after exhaustion of internal procedures and unlikely to result in litigation.

Even if adopted, will these external checks work? The Davies Report proposes significant new monitoring functions. Many questions, however, go unasked: How are the mentally handicapped to be represented at various stages of making and investigating a complaint? Can requests for more effective or less restrictive treatments be taken up in these procedures? Are investigative panels restricted to complaints of "untoward occurrences?" What remedies or penalties can be invoked if an authority fails to take corrective action? Is it realistic to expect staff members to report complaints against each other?

The proposed Code does not clarify the patient’s choice of forum. Instead, the Code of Practice simply recites the options. The aggrieved person is advised that a suggestion or complaint can be directed to a Ward Sister or Charge Nurse, to a District Administrator or the Area Health Authority’s Secretary, to the hospital's Secretary or Administrator, to the Regional Health Authority, to the Department of Health, or to "Members of Parliament and Ministers, and others." Compounding the uncertainty as to where and how to begin a complaint, two new bodies, the Health Services Commissioner and the Community Health Council, have been created under the National Health Services Reorganization Act of 1973. With a plethora of forums in which to be heard, potential complainants can become bewildered. Reviewing authorities may become uneasy about overlapping and competing areas of jurisdiction. The net result can be delays, frustration, and piecemeal remedies.

294. Id. Code of Practice ¶ 4.5, at 128.
295. Id. Code of Practice ¶ 2.1-2.6, at 125.
The Davies Report says little about another agency with jurisdiction to hear certain patients' complaints—the courts. Although one chapter concerns complaints that might go to court, the Code of Practice does not inform the patient either of his right to seek legal counsel or to initiate legal proceedings in appropriate cases. The Code's thrust is to divert complainants from such proceedings. For example, Investigating Panels would only take cases in which the complainant promised to forego his legal remedies. In these nonlitigious investigations, lawyers would generally be excluded from taking part as party representatives. For whatever reason, the subject of legal rights of patients was omitted from section 2 of the Code (Making a Suggestion or Complaint) and Appendix I (Suggested Paragraphs for Use in Admission Booklets or Handbooks). While perhaps the only feasible political tack, the Committee Report may retard the development of effective legal protections. By omission, it implies that legal recourse, whether for equitable or legal remedies or merely for legal opinion, is somehow unwarranted and ill-advised. The role of legal protections remains to be openly and fully explored.

2. Judicial Forums

English law, according to Lord Justice Leslie Scarman, provides fewer remedies for human rights invasions than does the law of other European Community nations. In the 1974 Hamlyn Lectures, Justice Scarman, of the Court of Appeal, urged courts and lawyers not to shrink from the challenges of "interpreting and guarding against the abuse of power, a modern, statute-based and more activist law." In the field of welfare law, he noted the inevitable conflict between citizen and bureaucracy,
observing that in any such conflict the citizen is at a substantial disadvantage.

The citizen may find himself without the physical or material resources, the expertise or knowledge to make his case against the government expert, who perfectly bona fide but mistakenly, may not act in a given case upon the view that the citizen has no entitlement.301

As a partial counterweight to this imbalance, Lord Justice Scarman proposed a more flexible system of dispensing legal advice and assistance.302 He also endorsed the public financing of representative or test case actions where a question of principle or policy of genuine public importance arose.303 This, he pointed out, is in keeping with the lawyer's traditional role as a defender of the oppressed.

Recent English court cases show that lawyers and judges can be found to assume that challenge. For example, residents in a mental institution had their voting rights restored after a county court found illegal disenfranchisement on the basis of mere hospital residence.304 A mental hospital inmate in a private prosecution proved he had been criminally assaulted by a male nurse, although the proceedings were subsequently ruled a nullity on a point of law.305 In a wardship action, Mrs. Justice Heilbron spared a young mentally retarded girl from an unjustified sterilization.306 Even where

301. Id. at 43-44.  
302. The lawyer has always liked to think that he is the natural champion of the weak and the oppressed. The new law of the welfare state conferring rights upon that sector of society will be too often frustrated unless those who have rights enforce them. Policy and the lack of money available for legal services in this new world of the law have combined to enfeeble the lawyer's challenge which, though new, strikes a very familiar chord—the protection of the weak.  
Id. at 86.  
303. Id.  
304. In re Handley, Warrington County Court (unpublished judgment, June 15, 1976). The Court determined that mental patients who were merely residents in a mental institution and not receiving active treatment were not to be considered patients for purposes of the election law. Section 4(3) of the Representation of the People Act, 1949 bars from voting anyone who is a patient in any establishment maintained wholly or mainly for the reception and treatment of persons suffering from mental illness or other mental disorder. The action was brought as a test case with the Registration Officer agreeing to treat the five named objectors as representative of all 574 Winwick Hospital patients inadvertently added and then struck off the Electors' Lists. In re Handley, Statement of Facts and Decision of the Registration Officer (unpublished memorandum, Mar. 31, 1976).  
unsuccessful or not fully determined, cases of individual injustice may still spur Parliament and society to reexamine and correct underlying deficiencies.

3. Administrative Forums

In Great Britain, several nonjudicial forums already provide some independent review of the complaints of the mentally disabled. The most significant of these bodies are the Health Services Commissioner, the Mental Health Review Tribunals, and the Mental Welfare Commission of Scotland.

a. Health Services Commissioner

The Health Services Commissioner hears complaints from National Health Services patients, including patients within mental handicap hospitals. Under the National Health Services Reorganization Act of 1973, the Commissioner, a Crown appointee, may investigate complaints made by or on behalf of any person who alleges that he has "sustained injustice or hardship" as a result of:

a) a failure in a service provided by a health services authority;

b) a failure of a health services authority to provide a service which was its function to provide; or,

c) any other action taken by or on behalf of a health services authority which involved maladministration.

The Commissioner has primarily an investigative and reporting power. He has no direct remedial powers, but could urge a health authority in a well-founded case to offer the complainant an apology, an explanatory meeting, a requested service, or a small *ex gratia* restitution.

Most of the Commissioner's cases settle small individual grievances. In at least three cases, however, service failures have been partly attributed to inadequate guidance from a central department, and further guidance has been urged. The Commissioner's First Report revealed an inclination to make more general recommendations and to dismiss a high proportion of cases. Of 612 complaints received in 1974, only 68 complaints were upheld in whole or in part. Nearly 60 percent (354 complaints) were rejected

308. *Id.* § 34(3).
310. "And it will be a special concern of mine, if I conclude that a particular grievance arises from a failure which is symptomatic of some general weakness in a procedure
as being outside the Commissioner's jurisdiction. Categories of nonjurisdiction involve broad discretion. Complaints are rejected on jurisdictional grounds if the health authority has not had "a reasonable opportunity to investigate and reply to the complaint;"311 if the complaint involved the diagnosis of illness or the care or treatment of a patient "taken solely in consequence of the exercise of clinical judgment;"312 or if the aggrieved person has or had a remedy before a tribunal or court of law.318

So far, few cases have touched on, let alone settled, complaints of mentally handicapped individuals. In its first 18 months, the Commissioner's office noted 5 cases involving the mentally handicapped. Those cases dealt with waiting lists for long-term care,314 inadequate supervision in a hospital occupational therapy department,315 delay in arranging hospital admission of a dying, severely mentally and physically handicapped child,316 supervision of a Down's Syndrome child in a general hospital,317 and patient discharge from a mental handicap hospital on short notice to relations.318 In each of those cases, except that concerning the Down's Syndrome child, health authorities were criticized.

Positive remedies, however, have not always been devised. For example, in the waiting list case, a vacancy was specially created but was rejected by the complainant as unsuitable for her son.319 In another case, a staff member in a mental subnormality hospital had criticized the hospital's lack of any written procedure for handling patient complaints. The staff member then lost his job because the complaints he raised created "friction in a department which was very hard to staff."320 Notwithstanding this finding, and the validity of the original complaint, the Commissioner was satisfied that there was no victimization.


312. Id. at Sched. 3. The Commissioner has, however, recognized that a complaint may have many components and may intertwine clinical and administrative aspects. Annual Report 1974-75, supra note 310, at 8.
315. Id. Case No. 94/74/75.
316. Id. Case Nos. 165/74/75 & 2/16/74/75.
317. Id. Case No. 5/74.
319. The commissioner reported: "I was dismayed, therefore, when the mother, whose burden was becoming clearly intolerable, felt unable to accept the place offered because she was not satisfied that the facilities were suitable." Annual Report 1974-75, supra note 310, at 33.
320. Id. at 42.
The ambit and remedial powers of the Health Commissioner are modest. In also wearing the hat of Parliamentary Commissioner, he is apt to inherit the public images which surround the British Ombudsman. His findings may be rejected and his suggestions ignored. To be effective, the Commissioner needs the cooperation of civil servants and has “too few weapons at his disposal to play the gladiator.” A recent study concluded that schemes such as the Parliamentary Commissioner could do no more than make “a basically sound civil service and administrative system marginally better.”

b. Mental Welfare Commission for Scotland

In Scotland, the Mental Welfare Commission, composed of 11 Commissioners appointed by the Crown, serves primarily an oversight function. Under Scotland’s Mental Health Act of 1960, the Commission’s members and staff investigate irregularities in care or treatment, visit patients under detention or guardianship, or those who request a private interview, and prepare reports to authorities on welfare matters pertaining to mentally disordered patients generally. In cases of detention, the Commission may order the release of improperly detained patients. The Mental Welfare Commission is under a statutory duty generally to exercise protective functions in respect of persons who may, by reason of mental disorder, be incapable of adequately protecting their persons or their interests, and, where those persons are liable to be detained in hospital or subject to guardianship . . . their functions . . . shall include, in appropriate cases, the discharge of such patients in accordance with the said provisions.

The Commission resolves individual and group complaints. It investigated and published its findings on the exploitation of mentally handicapped

321. “The popular impression,” writes a columnist of The Times, “has been of rather grey men doing little bits of good in a quiet way, but too close to the official machinery, in their experience and attitudes ever to be a really powerful force for individual liberties.” The Times (London), Aug. 13, 1975, at 12.


323. Id.

324. Mental Health Act, 1960, 8 & 9 Eliz. 2, c. 61 (Scot.).

325. The Mental Welfare Commission for Scotland is empowered “to secure the welfare of any patient suffering from mental disorder by- (i) preventing his ill-treatment; (ii) remedying any deficiency in his care or treatment; (iii) terminating his improper detention; or (iv) preventing or redressing loss or damage to his property.” Id. § 4(2) (c) (Scot.).


327. Mental Health Act, 1960, 8 & 9 Eliz. 2, c. 61, § 4(1) (Scot.).
persons “boarded out” on small farms. The Commission has conducted three formal inquiries into alleged patient maltreatment, considered some 700 maltreatment complaints, and discharged 7 detained patients. Twice a year its personnel are to visit each of Scotland’s 54 public mental institutions. The Commission also monitors and reports on the protection of the mentally disabled’s property and other interests. The Commission’s jurisdiction includes informal patients and mentally disordered persons living in the community. In explaining this breadth of coverage, the Commission has emphasized that “informal patients may be subject to ill-treatment or deficiency in care or treatment in the same way as formal patients.”

c. Mental Health Review Tribunals

In England and Wales, administrative tribunals play a role narrowly circumscribed by the Mental Health Act. At prescribed intervals, formal patients may request a Mental Health Review Tribunal, composed of a medical specialist, a legal specialist, and a lay person, to review their applications for discharge from a hospital or guardianship. Unlike Scotland’s Mental Welfare Commission, the tribunals have no power in relation to informal patients or other mentally disordered persons not under compulsory care. Nor may they review the legality or propriety of involuntary hospital admissions made for purposes of observation or treatment. A tribunal may only direct a patient’s discharge if satisfied that the patient is not then suffering from a form of mental disorder, or, if in the “interests of the patient’s health or safety or for the protection of other persons,” he no longer need be detained, or, in a narrower category of cases, if released, the patient would “not be likely to act in a manner dangerous to other persons or to himself.” The Mental Health Act limits the tribunal’s dispositions to discharge or retention. Some tribunals, however, adjourn hearings to put

329. MENTAL WELFARE COMMISSION FOR SCOTLAND, A DUTY TO CARE 17 (H.M.S.O. Edinburgh, 1974). Through the work of its Medical Commissioners and Medical Officers, the Commission affords the opportunity of a private interview to all detained patients in public mental institutions, to persons in the community who are subject to statutory guardianship, and to those informal hospital patients who request an interview. It also has the authority to initiate interviews with patients. Interview with Dr. Anne N.M. Brittain and Dr. J.M. Loughran, Medical Commissioners, in Edinburgh (Apr. 28, 1974).
330. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72 § 123(1). See notes 266, 268 & accompanying text, supra.
331. Id. § 123(1)(c).
pressure on hospital or social service authorities to consider alternative dispositions.\textsuperscript{332}

For the mentally handicapped, the tribunals have been of little use for the following reasons: few mentally handicapped patients are formal patients; few of those formal patients will be aware of, or receive notice of, their rights; patients requesting tribunals are not provided legal aid as a matter of course; and the burden of going forward at every stage of the proceeding lies with the patient.

The tribunals' mission is far narrower than their original framers intended. The Royal Commission, which laid the groundwork for the Mental Health Act, wanted tribunals to decide whether the type of care provided detained persons was the "most appropriate" and whether any alternative form of care might be more appropriate to the patient's needs.\textsuperscript{333} Unfortunately, that critical recommendation was not incorporated in the Act.

\textbf{E. Implementation of the United Nations Declaration}

Not all categories of the mentally disabled, George Lee, General Secretary of the National Society for Mentally Handicapped Children, explains, have equally shared in recent advances.\textsuperscript{334} In his view, the mildly and moderately retarded have long had special educational and other essential facilities. Serving the severely retarded has been more problematic. For this reason, he finds it difficult to evaluate the implementation of the rights of the retarded. The following Section contains Mr. Lee's ratings on the application of the 1971 United Nations Declaration, supplemented by materials collected by the author.

1. Article I: Equal Rights

Compliance with Article I of the United Nations Declaration was seen by Mr. Lee as being very good. The basic rights of the mentally retarded in Britain, however, are often described as turning on the broad discretion of local officials. At the King's Fund Centre, Mr. Lee, in discussions on voting and marriage, for example, stated that there is "not a clear answer on any of the rights of the mentally handicapped."\textsuperscript{335} For instance, a retarded

\textsuperscript{332} Personal observation of Mental Health Review Tribunal hearings held at Rampton Hospital, June 1974.

\textsuperscript{333} \textit{REPORT OF THE ROYAL COMMISSION ON LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY}, CMND. No. 169, at ¶ 445 (H.M.S.O. London, 1957).

\textsuperscript{334} Mr. Lee kindly made available for publication these evaluations contained in a letter to the author written Jun. 10, 1975 (on file at the Catholic University Law Review).

\textsuperscript{335} Meeting with Mr. Justice Beattie, New Zealand Supreme Court, at King's Fund Centre, London (May 20, 1975).
person who resides in an ordinary home may vote, while an equally retarded person who lives in a mental institution may be automatically disenfranchised. Moreover, a retarded person can be turned away from the polls on the basis of an election officer’s on-the-spot decision that the potential voter is “manifestly incompetent to fill in the election form.” In some places registrars allow obviously retarded persons to obtain marriage licenses, while elsewhere licenses are denied. Because the Mental Health Act forbids unlawful sexual intercourse (i.e., nonmarital sex) with a severely retarded female, some mistakenly believe this prohibition extends to marriage.

Legislation and regulation may inhibit mentally retarded persons from enjoying the same rights as others. Sexual expression, as mentioned, is one area. Another is access to the courts. Under section 141 of the Mental Health Act, before filing a legal action a mentally disordered patient is first required to have the prior permission of the High Court and to make a substantial showing that a staff member acted in bad faith or without care. The scope of this staff immunity from civil or criminal prosecution has been interpreted with great latitude. A third area of discrimination concerns the placing of mental institutions outside the scope of various inspections and regulations. For example, residential facilities for mentally handicapped children are not covered by the general standards, inspections, and related safeguards applied to facilities for other children.

2. Article II: Developmental Services

Respect for Article II provisions dealing with proper education, care, and

336. Id.
337. Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72 § 127(1). See also id. § 128 (unlawful sexual intercourse with patients).
338. Section 141(2) states:
   No civil or criminal proceeding shall be brought against any person in any court in respect of any such act without the leave of the High Court, and the High Court shall not give leave under the section unless satisfied that there is a substantial ground for the contention that the person to be proceeded against has acted in bad faith or without reasonable care.
   Under section 141(1), to gain this immunity the proposed defendant need only perform “any act purporting to be done in pursuance of [the Mental Health] Act or any regulations or rules thereunder . . . .” This statute has been broadly construed. See Pountney v. Griffiths, [1975] 2 All E.R. 881 (male nurse who struck a Broadmoor patient while on duty, purportedly to control the patient, entitled to statutory protection from criminal prosecution), aff'g sub nom. Regina v. Bracknell Justices, ex parte Griffiths, [1975] 1 All E.R. 900.
339. DHSS, MENTALLY HANDICAPPED CHILDREN IN RESIDENTIAL CARE (H.M.S.O. 1974). This Study Group concluded that “under present legislation nonhandicapped and handicapped children living in children’s homes are better protected by the Community Homes Regulation and the Children Act of 1958, than are mentally handicapped children.” Id. at 42.
training is rated as “very good.” Here Mr. Lee has drawn attention to the
distinction between the educationally subnormal, who have always received
special education, and the severely subnormal, provided for only since 1971.
A minority in the “Special Care” category or in hospital schools, he points
out, still have “patchy” services.

Access to services may also turn on where the disabled person lives. Such
regional variation may be a natural consequence of permissive legislation. At
the 1967 Stockholm Symposium, Colonel G.H. Verburgh suggested that for
political reasons, British social legislation has been of a permissive, not
mandatory character.340 “This is the reason,” he explained, “why the
provisions for the S.S.N. [severely subnormal] made by the local authorities
may vary considerably in different parts of the country and between the
municipalities and the country districts.” Even where subsequent legisla-
tion, such as the Education (Handicapped Children) Act of 1970,342 or
the Chronically Sick and Disabled Act of 1970,343 has required certain
educational and informational services, not all local authorities have dis-
charged their statutory duties or appreciated the nondiscretionary nature of
those duties.344 Through a postal questionnaire to parents of mentally
handicapped children, the Oxford Centre for Socio-Legal Studies has record-
ed similar perceptions by parents.345 Due to regional variation in retarda-
tion services, some parents reported moving their home, or considering such
a move, in order to come under a particular local authority with better
services.346 Other parents reported long battles with the authorities to get
recognition and suitable placement for their child’s special needs. Respond-
dents to the questionnaire emphasized the need for persistence—sometimes

340. G.H. Verburgh, The Optimum and Minimum Legal Provisions Required for the
Mentally Retarded, ILSMH Symposium on Legislative Aspects of Mental Retardation
(Stockholm, June 1967).
341. Id. at 5.
342. See discussion in text accompanying notes 270-283, supra.
343. Chronically Sick and Disabled Act, 1970, c. 44.
344. Parents asking for help for their retarded child “still go cap in hand” and “feel
they have no rights,” Address by Dr. G.B. Simon, Director, Institute of Mental Subnor-
345. Dr. S. Lloyd-Bostock “Postal Questionnaire to Parents of Mentally Handicapped
Children,” (Oxford Centre for Socio-Legal Studies, Wolfson College, 1974) (unpub-
lished paper on file, Catholic University Law Review). Based on 97 replies, the re-
searcher concluded:

Variation was apparent in local provision of schools, hostels, playgroups, train-
ing centres, facilities for short term care, individual teachers, speech therapists
and practical help . . . . In some cases the knowledge that these services were
available elsewhere led to resentment against parents’ own authority.

Id. at 5.
346. Id.
in the face of direct opposition from officials—and 40 percent said they had had to help themselves to a great extent.\textsuperscript{347} One parent was said to speak for many with her comment “the wheels of authority grind very slowly.”\textsuperscript{348}

3. Article III: Economic Security and Work

The economic position of the retarded is described as “good.” While government and industry have long made special training facilities and employment available to the mildly disabled, there is considerable reluctance to train and employ the severely disabled.\textsuperscript{349}

4. Article IV: Home and Community Life

Opportunities for home and community life are characterized as an area of “excellent promise” but “only good” implementation.\textsuperscript{350} Mentally retarded children, sometimes through incorrect or incomplete information, are placed in restrictive and isolated settings.\textsuperscript{351} Sometimes these children and their parents thereby lose contact with each other. In 1972, the Department of Health and Social Security issued a circular to mental handicap hospitals directing them to take steps to reduce various forms of abandonment.\textsuperscript{352} In 1974, the Campaign for the Mentally Handicapped, a pressure group concerned with more integrated and developmental approaches for the retarded, published a monograph, Whose Children.\textsuperscript{353} This statement points out the deprivations of a homelike environment that 8000 mentally retarded children in hospitals continue to suffer. James Elliot of the King’s Fund Centre and other concerned individuals have asked whether each mentally handicapped child in a hospital or in care outside of home should

\textsuperscript{347} Id. at 6.
\textsuperscript{348} Id.
\textsuperscript{349} Letter from George W. Lee, supra note 334.
\textsuperscript{350} Id.
\textsuperscript{351} D. Pillin, THE HANDICAPPED CHILD: RESEARCH REVIEW (1973). “In conclusion it can be said that most institutional environments which have been studied do have adverse effects on the development of subnormal children.” Id. at 80.
\textsuperscript{352} According to Verburgh:
The legacy of fear of the large impersonal Mental Deficiency Hospital, where the retarded used to be shut up in institutional conditions more like those of prisons with little or no personal care and no provision for their meaningful occupation, has led many people to hide away their retarded children or to keep them long after they themselves were able to care for them properly. G.H. Verburgh, supra note 340, at 13.
\textsuperscript{353} These steps consisted primarily of the encouragement of visiting and other ties between the resident and his family.
\textsuperscript{353} C.M.H., WHOSE CHILDREN? (Monograph, Campaign for the Mentally Handicapped, 1974).
have an assigned social worker. That worker would actively plan and place the child in alternative homes or assist natural parents to again provide domiciliary care. Many retarded adults will also need relocation assistance.

5. Article V: Guardians

Guardianship was termed "unsatisfactory" by Mr. Lee and others. The majority of the retarded, living independently in the community, do not need guardians. The very small remainder who do are unlikely to be under any form of guardianship or alternative supervisory service. To fill a vacuum, hospital superintendents or local social service directors may assume an entirely de facto guardianship for some of their clients. With a trend toward more community based care, there is great concern that retarded persons will lack sufficient support and guidance. Many parents believe that they automatically remain guardians of their children even after age 18. While guardianship is felt to be a tarnished concept (or at least a tarnished word), representatives of parents' associations agreed that "something must be done," and that new types of advocacy and guidance services were needed.

6. Article VI: Legal Protection

Respect for Article VI was rated "fair." There is growing concern for the rights of mentally retarded and other mentally disordered offenders. For

354. Interview with James Elliot, Associate Director, King's Fund Centre (multi-disciplinary research and information center to promote better health and care standards) in London (May 20, 1975).
355. For the year ending March 31, 1973, only 28 mentally handicapped persons in England were placed under guardianship. The total of all such persons admitted under the provision of section 33 of the Mental Health Act, 1959, was 158. See comments of B. J. Hadkinson, DHSS, in Alternatives to Hospital (and Hostel) Care at 11 (Hodgson, ed., National Society for Mentally Handicapped Children, 1974). As of March 31, 1974, the total number had fallen to 125. DHSS, A REVIEW OF THE MENTAL HEALTH ACT 74 (1976).
356. Meeting with Mr. Justice Beattie, supra note 335.
357. Letter from George W. Lee, supra note 334:
The severely subnormal until recently have been considered (but not in a legal sense) as the wards of their parents prior to entry into hospital where the Medical Superintendent has been regarded as their spokesman. With the ending of institutionalization as a policy, the need for a resolution of the guardianship problem is beginning to make itself felt now that more adolescents and adults are in the community. Having in mind the distinct possibility of a revision of the Mental Health Act this Society, in common with other interested parties, is preparing its own material in order to be in a position to make recommendations bearing on guardianship and other matters.
358. See, e.g., Protection of Mentally Retarded Persons (Evidence) Bill, 1975 (pri-
example, M.P. Christopher Price introduced legislation, later withdrawn after a successful judicial appeal, concerning the admissibility of confessions made by retarded suspects to police interrogators. Among the devices to limit undue pressure, the bill would have required the presence of a solicitor or parent at any interrogation of retarded persons.

7. Article VII: Procedural Safeguards

Mr. Lee rated English compliance with Article VII as "good."

F. Some Observations For the Future

The machinery for securing the rights of the English mentally handicapped is in need of overhaul, if not invention. This need for reassessment is recognized and reflected in many ways. The work of the Health Services Commissioner and other statutory review bodies helps disclose the gravity of the underlying human and social problems. The Wessex and other research projects demonstrate that, with proper community facilities and services, no mentally handicapped children need be placed in hospitals. Indeed, many more long-stay residents of isolated institutions, whose disabilities were once seen as barring community living, are now found suitable for transfer to hostels in ordinary neighborhoods. Voluntary members' bill, House of Commons); Memorandum from Stanley Herr to MIND and to Christopher Price, M.P., "Comments on a Proposed Bill to Regulate the Admissibility of Statements in Evidence of Mentally Retarded Persons" (Mar. 6, 1975). See generally Dr. Roger Hood, "Penal Policy and the Rights of Prisoners" (unpublished paper delivered to Frank Dawtry Memorial Seminar, University of Leeds, Jun. 25, 1976).


360. See notes 223-27 & accompanying text, supra.

361. See notes 307-33 & accompanying text, supra.

362. See Kushlic, supra note 228.

363. Indeed, the gains in adaptive behavior made by the nonambulant and most severely physically handicapped children placed in hostels instead of hospitals may "seriously challenge the widely held view that for this category of child in particular, hospital care under the aegis of trained nurses is not only the treatment of choice, but that lack of such treatment in situations outside of such hospital settings could seriously decrease the child's life chances." J. Smith, S. Nicholson, P. Williams, A. Tamplin & A. Kushkick, "A Comparison of the Changes which Took Place Among Two Groups of Severely Subnormal Children Who Were Receiving Different Forms of Residential Care" (Health Care Evaluation Research Team, Winchester, England, 1973).

tary organizations are currently pressing for more affirmative legal approaches to protect the rights of the mentally disabled. Leaders of the British legal profession, such as Lord Hailsham and Lord Justice Scarman, have urged the adoption of a Bill of Rights to protect the individual against oppression from either the bureaucracy or Parliament.

Judged against the United Nations Declaration of 1971, the Mental Health Act of 1959 does not adequately protect the rights of the mentally disabled. After 17 years of implementation the Act reveals many gaps and outdated features. Amendments could well incorporate, *inter alia,* (1) declarations against blanket forms of discrimination applied to those labelled mentally disabled; (2) added definitional and substantive safeguards for persons who might be subject to unnecessary, erroneous, or unduly restrictive confinements or other fundamental deprivations; (3) clarified responsibilities of local authorities for community care and supervision; and (4) more coherent machinery for asserting the rights and interests of mentally disabled individuals. To some consumer organizations, the main task ahead is to gain the support of informed public opinion for new legislation. With greater public awareness of the problems, they hope Parliament will strengthen human rights safeguards.

To satisfy the nation's conscience, the state, Lord Justice Scarman wrote, has had to "move into the empty spaces of the law, the deserts and hill country left uncultivated by distributive justice, and there to make provision for society as a whole, and for those not strong enough to provide for themselves." That work, so crucial to the lives of the disabled, is by definition always unfinished. Social justice, for the mentally handicapped no less than others, "requires the law to be loaded in favour of the weak and the exposed, to provide them with financial and other support, and with access to courts, tribunals, and other administrative agencies where their rights can be enforced." A Departmental review of the Mental Health Act, underway in 1976, could give greater recognition to that compensatory principle. Then Parliament, aided by consumer groups, must translate that principle into a more coherent statutory framework.

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365. See notes 225 and 287, supra.
367. According to Mr. Lee, change in Britain is "largely achieved by persuading Ministers and officials to take administrative action, or, if a major change in the law or new legislation is required, through the united action of interested members of Parliament." See note 357, supra.
368. L. SCARMAN, supra note 267, at 29.
369. Id.
370. See note 227, supra and Herr, "A Note in Response to Appendix III" (Oct. 7,
V. THE NETHERLANDS: A FAITH IN GENERAL RIGHTS

The structure of services and legislation in the Netherlands is intricate, fragmented, and complex. The private sector is the primary provider of services. Public authorities assume only residual roles. They provide general legislative, financial, and regulatory oversight for the care of the retarded. Legislation divides enforcement responsibilities among at least five Ministries, each dealing with a separate sphere of habilitation and care. This legislative approach seeks to accommodate the retarded within administrative structures serving all citizens. While its strength is integration of services, its weakness is a lack of coordination in ensuring appropriate services to the retarded individual. Dutch spokesmen for the retarded are giving increased attention to the individual's legal rights in an intricate welfare system.

A. National Legislation

In the Netherlands, social legislation emphasizes generic rather than special services for the retarded. According to Dutch leaders, the "right of the mentally retarded to an optimum development of their capacities and therefore to the necessary material assistance, to be provided from public funds, [is] recognized and guaranteed by law." This view is based not on express legal declaration but on the sum of laws and public policy, including social security, welfare, and insurance measures. Indeed, as a leading social services specialist puts it, "a separate general act for the handicapped is unknown in the Netherlands."

Unique features of Dutch retardation services compound the problems of coordinating policy, service delivery, and program planning. Education-
al, residential, and vocational training services are provided by a multiplicity of private organizations. These, as a rule, are organized along religious or ideological lines. With governmental supervision dispersed across five separate ministries, there is a further risk of unevenness in the quality and provision of services for the retarded. With characteristic official understatement, one ministry conceded that this pattern makes "perhaps for a somewhat complex organization [which] may not be the most economical and efficient one." The Dutch National Association for the Care of the Mentally Retarded (N.O.Z.) an umbrella organization for consumer groups and service providers has pointed to incoherence in social legislation.

It must be admitted that up to now the ministries follow no general administrative policy based on a number of central principles. Such laws as have already been passed or are in the process of preparation have consisted up till now of pieces of partial legislation for the various sectors, issued separately and with insufficient co-ordination by the ministries concerned.

This general legislation concerning health, labor, education, and social work services has also been criticized as "not paying enough attention to the specific problems of rehabilitation” for the disabled.

In 1968, the Dutch Government established an Interdepartmental Steering Committee on Rehabilitation to increase public policy coordination. The Steering Committee is, however, purely advisory. Its value and influence on national policy has so far been rated “very low” and of “no significance.”

Public policy still emphasizes governmental subsidy for private initiatives with only limited central oversight and direction. To alter this basic pattern, the Government has been urged to “impose compulsory measures for the organization, management and execution of, among other matters, the health services and the social services.”


Some special provisions for the mentally handicapped do exist. The Act of 1884 authorizes involuntary civil commitments and regulates admission and care in secure residential facilities. As public officials acknowl—
edge, this Act, preserving distinctions between the type of care rendered in "open" and "closed" wards, is badly outmoded. The Special Education Regulations of 1967 require special approaches in identifying and educating handicapped children. These Regulations have several notable features, including a screening committee which determines a child's need for admission to special schools. Coverage is broad, as eligibility depends on need, not on definition of disability (disability and its subcategories are not defined in either the regulations or statutes). Public payment is made for all expenditures attributed to the child's education. Minimum standards fix staff ratios, teacher qualifications, curriculum, and physical facilities.

By law, retarded children, like their peers, are obliged to attend schools. Some schools still are lacking special education programs and the facilities with which to provide such services. A 1972 publication of the Ministry of Public Health and Environmental Hygiene states: "It is estimated that the existing provisions cover practically all those mentally retarded children who need special education."

2. General Provisions

While no act singles out the mentally retarded, some acts benefit broad classes of disabled persons. For example, the Exceptional Medical

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384. According to the Inspectorate of Mental Health, a new mental health act is under preparation to replace the 1884 legislation in which "activities of prevention and community care will have their proper place." MENTAL HEALTH, supra note 377, at 13. As of March 1974, such an act had yet to be introduced. Interview with P. J. Blommes-tijn at The Hague (Mar. 28, 1974). Through 1976, there was still no new mental health act. Letter from Jan Meiresonne to author (July 14, 1976).

385. The 1967 Regulation is part of the Primary Education Act. Interview with Jan Meiresonne, supra note 374.

386. Id.

387. Compulsory Education Act, 1909. The upper age for compulsory education has recently been raised to 16. CARE IN THE NETHERLANDS, supra, note 371, at 28.

388. Interview with Jan Meiresonne, supra note 374.

389. MENTAL HEALTH, supra note 377, at 16 (emphasis added).

390. CARE IN THE NETHERLANDS, supra note 371, at 24. For a summary of applicable Dutch health care, social welfare, educational, and vocational rehabilitation, see id. at 22-33.

391. See, e.g., Wet op de Arbeidsongeschikt-Heidsverzekering [W.A.O. Disablement Insurance Act]. While limited to wage earners who lose their work capacity, the Dutch Government proposes to extend this Act's benefits to nonemployed persons, including those with congenital developmental anomalies and handicaps, such as the mentally retarded. The new Act, Algemene Arbeidsongeschiktheids Wet [General Disablement Insurance Act], is to be introduced in 1977. CARE IN THE NETHERLANDS, supra note 371, at 31. Most social legislation is of general application and therefore includes the retarded. See, e.g., Ziekenfondswet [Health Insurance Act]; Ziektewg [Sickness Benefits Act].
Expenses (Compensation) Act, described as a "Rehabilitation Act," meets the costs of very prolonged treatment or nursing through national social insurance. Intended primarily for medical expenses, the Act also covers the mentally retarded in institutions, boarding schools, certain day care centers, and hostels. Vocational rehabilitation laws provide for sheltered employment and employment quotas for disabled persons in ordinary employment. Through planning, subsidy, and supervision, social welfare regulations support specialized social work for the mentally retarded and their families, day care centers for severely handicapped children and adults, and hostels, respite care, and special welfare payments for the handicapped.

B. Enforcing Rights

Retarded persons also look to general rather than special provisions in enforcing their rights. Here, the Dutch have relied on the force of political pressure and public criticism.

The legal rights of retarded persons, in the opinion of Dutch leaders, are not adequately protected on an individual level. Provisions for effective


393. CARE IN THE NETHERLANDS, supra note 371, at 26, 29.

394. Wet Sociale Werkvoorziening—W.S.W. (Special Employment Act, 1969). Under the W.S.W. Act, the local authority is legally responsible for the provision of sufficient work opportunities under sheltered conditions. CARE IN THE NETHERLANDS, supra note 371, at 32.

395. Wet Plaatsing Mindervalide Arbeidskrachten (The Disabled Workers' Employment Act, 1947). Under this Act, every employer of more than 20 persons is to have 2 percent of his total labor force composed of disabled persons. The Act is described as "no longer of any practical significance." In 1975, the Minister for Social Affairs established a temporary subsidy, expiring July 1976, for employers hiring an unemployed disabled person. This subsidy amounted to 60 percent of that new employee's wage. Id. at 33.

396. Id. at 27-28.

397. As Jan Meiresonne, N.O.Z.'s executive director, explained: "In the Netherlands no official special administrative mechanisms are available for enforcing the retarded person's rights. This means that for their enforcement, only the common, general mechanisms for all citizens are available." Interview with Jan Meiresonne in Utrecht (Mar. 27, 1974).

398. Id.

399. CARE IN THE NETHERLANDS, supra note 371, at 38-39. Interviews with P. J. Blommestijn at The Hague (Mar. 28, 1974); Myrna Njokiktji, Dept. of Justice, at The Hague (Mar. 28, 1974); Jan Meiresonne in Utrecht (Mar. 26-27, 1974). Mr. Meiresonne elaborated: [In the Netherlands there is a gap in the safeguarding of the individual rights of the individual mentally retarded person. This concerns mostly the
guardianship or other forms of representation are not available.\textsuperscript{400} The grievances of the inarticulate or vulnerable may never reach appropriate officials, let alone the media or the machinery of justice. For several years, N.O.Z. and other consumer organizations have campaigned for guardianship law reforms.\textsuperscript{401} One proposal, later withdrawn, sought regular appointment of guardians for certain classes of retarded persons at the time of majority.\textsuperscript{402} Existing guardianship procedures have been criticized for their formality and expense.\textsuperscript{403} Moreover, N.O.Z. has pointed out that Dutch law, through the legal concept of "curatele," is still concerned primarily with affairs of property and not of persons.\textsuperscript{404} As a result, in too many instances, services and rights exist on paper but are inaccessible to retarded persons and their families.\textsuperscript{405}

In interviews, Dutch specialists stressed the retarded individual's need for guidance, information, and representation to make personal rights effective. While satisfied with the safeguards for collective interests, Mr. Jan B. Meiresonne of N.O.Z. decried the lack of legislation for securing individual rights, particularly for retarded persons reaching the age of majority.\textsuperscript{406}

safeguarding of the rights of the mentally retarded who have reached majority. While having legal representatives (parents, guardians) during their minority, in their majority most of the mentally retarded have no legal representative, except if being under "curatele" [guardianship of the property]. There is no guardianship of the person then. The N.O.Z. is now promoting legal provisions for this—making a proposition for a law in which is introduced a guardianship of the person, carried out by individuals or agencies. It is hoped that the legislators will take over these propositions.

\textsuperscript{400} Letter from Jan Meiresonne to author (July 14, 1976).
\textsuperscript{401} Id. Current law only provides for plenary guardianship of incompetent adult retarded persons.

\textsuperscript{402} Interview with Jan Meiresonne in Utrecht (Mar. 26, 1974).

\textsuperscript{404} In addition to the "curatele" [prolonged minority of incompetent persons], N.O.Z. proposes a "mentorschap" [mentorship] for moderately and mildly retarded persons (primarily for personal, but also for property matters), and a "beschermingsbewind" [power of protection] for property affairs of retarded adults (apparently a form of limited guardianship).

\textsuperscript{405} To date, the Dutch Government has not adopted the N.O.Z. proposals. Letter of the Minister of Justice to Jan Meiresonne (July 7, 1976) (ref. no. 367/676). The Minister is preparing an act for more effective protection of retarded persons' property affairs. Until further study in cooperation with N.O.Z. can be undertaken, he has deferred taking a view on mentorship.

\textsuperscript{406} Interview with Jan Meiresonne in Utrecht (Mar. 27, 1974). He elaborated:

Until now there appeared no special need in the Netherlands to create special administrative mechanisms. Generally speaking there is no need to go to court at all, although the common courts (common court, court of appeal, supreme
This problem is not unique to the retarded. A leading rehabilitation policy maker, Mr. P.J. Blommestijn, Head of the General Department of Old Age Care and Social Rehabilitation, personally believes a system of representation is needed for persons in long-stay institutions generally. These representatives or spokesmen would offer advice to residents, mediate with their custodians and external agencies, and provide an additional link between the resident and the outside world. In this role the so-called “helping person” would complement and not displace parental authority. This system, in Blommestijn’s view, should be designed to assist persons in normal day-to-day situations, rather than being confined to emergency or abusive situations. Besides the mentally retarded, other groups of dependent and institutionalized persons such as the elderly, the physically infirm, and the juvenile in care might benefit from a similar type of assistance. In Mr. Blommestijn’s opinion, two prerequisites for the success of this scheme are: (1) some formality of appointment, and (2) continuity of contact.

Ministry of Justice officials agreed that advocacy for some retarded persons living outside their own homes would be desirable. To Ms. Myrna Njiokiktjien, inspector of Private Institutions in the Ministry’s Child Welfare Branch, the institutionalized child needs a “Children’s Ombudsman” to hear complaints and investigate any irregularities in treatment. Such an ombudsman, she personally believes, should be concerned with mentally retarded young persons.

The Netherlands has no special administrative machinery for safeguarding children and adults in institutions for the retarded. At present, neither the Ministries' inspectorates nor the family guardianship program fully protects their rights and interests. The inspecting services, as Mr. Meiresonne pointed out, do not have enough staff to visit and regulate all care facilities for the retarded in an adequate way. “Family guardianship,” an impor-
tant model for future laws on limited supervision, is now used only for a small minority of mentally retarded children who face parental neglect. At present, retarded persons in institutions, unvisited and in need of "parent substitutes" and surrogates, are not served by family guardians. Moreover, existing guardianship programs vary in quality depending on the size of the case load, the conflicts of interest of the professional guardian, and the lack of clarity in specifying the guardian's minimum obligations to wards.

The judiciary, in theory accessible to all, may, in the absence of a guardian or a vigorous friend, be out of reach for the friendless. Interviewees were unaware of any judicial decisions clarifying or enforcing the rights of the mentally handicapped. Dutch courts, however, can act on behalf of children and youths whose physical or mental well-being is neglected or endangered. In this role, juvenile court judges have ultimate responsibility for children made wards of private guardianship agencies, committed to the care of a Child Welfare Board, committed to the government care following a boarding-out order, or otherwise placed under supervision. Generally these children remain in their parental homes under the supervision of family guardians. To secure a child's proper care and upbringing, the juvenile judge may, however, place him in an institution, including an educational institution for "mentally defective minors" or for "working mentally defective minors," or may board him out with foster parents. In discharging these responsibilities, courts are empowered to receive information from area Child Welfare Boards, to obtain reports and assistance from private guardianship agencies, to order the minor's physical or mental examination in observation centers, to require alternative boarding-out provisions, and to otherwise obtain care and protection for the neglected or mistreated retarded child. A child's institutional treatment may be subject to judicial review. If

411. See M. ROOD-DE BOER, CHILD CARE IN THE NETHERLANDS 10 (1966), which characterizes family guardianship as a supervisory measure for a child threatened with moral or physical danger. The parents retain parental rights and the child is assigned a family guardian for a period of one year.


413. Some 60 private organizations administer family guardianship programs. Those agencies employ over 200 social workers who in turn oversee the work of some 7800 private guardians appointed by juvenile court judges for some 20,000 young people. Two of those agencies specialize in providing guardianship services for the mentally retarded: the William Schrikker Voogdij Stichting, Amsterdam, and Dr. Schreider van der Kolk, The Hague. Interview with Messers. Veira and Hanrath, Child Guardianship Branch, Dep't of Justice, at The Hague (Mar. 28, 1974).

the juvenile court finds the institutional environment unsuitable, it may remove a juvenile ward to a more favorable developmental setting.\textsuperscript{415} Journalistic exposure, parliamentary inquiry, and campaigns by private pressure groups can and do bring some treatment deficiencies to light.\textsuperscript{416} For example, an aggrieved resident or his parent or friend might enlist N.O.Z.'s aid in taking up a complaint with the government ministry responsible for funding a private institution.\textsuperscript{417} If the complaint concerned some widespread deficiency, N.O.Z. might lobby for statutory or administrative reform. For example, since 1973 this consultative agency has been developing and taking up legislative proposals for personal assistance for retarded persons over the age of 20.\textsuperscript{418} If adopted, the N.O.Z. proposal would ensure that every retarded person has the means to have his interests represented and his rights enforced.

A personal advocate is seen as the retarded person's alter ego. Under present practice, institutions will admit into care any mentally retarded person who does not actively protest.\textsuperscript{419} Lack of objection can be regarded as equivalent to consent even in the case of an adult. Mr. Meiresonne has convincingly urged that as a personal advocate, "the guardian in cooperation with the mentally retarded person should officially make a contract and can be officially responsible" for safeguarding the well-being of retarded adults placed in institutional settings.\textsuperscript{420} At present many retarded adults lack any guardian, let alone a format for participation in decisions affecting their futures. Even if actively concerned, a retarded person's parents may be discouraged from making complaints or suggestions for improved care. With a limited number of residential places and long waiting lists for alternative accommodations, parents may feel there is little or no choice. Furthermore, without a strong system of central inspection, they may be reluctant to press complaints or unaware of the possibility of doing so.

\textsuperscript{415} Interview with Ms. Njiokiktjien, \textit{supra} note 408.
\textsuperscript{416} Problems in Dutch retardation services, however, are systemic. \textit{See} CARE IN THE NETHERLANDS, \textit{supra} note 371, which notes gaps in legal safeguards and concludes:
\begin{quote}
There is no official policy for the care of the handicapped and in particular of the mentally handicapped. This is the result both of the fragmentation of, and the lack of coordination between the responsible authorities and also of the complicated structure of the services themselves between which there is too little cohesion.
\end{quote}
\textit{Id.} at 37-40.
\textsuperscript{417} Interviews with Jan Meiresonne in Utrecht (Mar. 26, 1974), in Dublin (Sept. 16, 1975).
\textsuperscript{418} N.O.Z., \textit{INTERIM REPORT}, \textit{supra} note 403.
\textsuperscript{419} Interview with Jan Meiresonne in Utrecht (Mar. 26, 1974).
\textsuperscript{420} \textit{Id.}
None of this discussion presupposes that Dutch institutions are "bad places." It instead reflects the inequalities in information and bargaining power between the purchasers and providers of institutional services. Given that imbalance, consumers need advocates with specialized knowledge and oversight agencies with powers to do justice for the retarded.

C. Legislative Reforms and Human Rights

Dutch mental retardation services are in a state of transition. To quote one Dutch official: "Everything is not a bed of roses in the Netherlands." Mr. A. Linde, Head of the Social Rehabilitation Department of the Ministry of Cultural Affairs, Recreation and Social Work, further explained that there are some "matters which have been left undone for too long; some of them are even fundamental points which might undermine the system we are building up unless something is done about them soon." Two assets in effecting those reforms are first, official candor in recognizing service deficiencies and second, new leadership by vigorous and progressive national spokesmen for the mentally retarded.

What are some of the shortcomings in existing legislation? Mr. Linde has found "regrettable" the lack of an organized system of early diagnoses of mental retardation, research, and community education geared to greater social acceptance of the intellectually handicapped. In 1971, Mr. Bloemestijn listed legislative gaps and proposals for closing them. In a 1974 interview, he reiterated the following defects in Dutch legislation for the handicapped:

1. the lack of organization for early detection and treatment of mentally handicapped children;
2. undue emphasis on in-patient clinical care under social insurance legislation;
3. lack of authority for "longitudinal and inter-disciplinary rehabilitation work;"

421. On September 7, 1973, the author was indeed fortunate to visit the congenial "Eemeroord" institution and a gracious residential facility in the Baarn vicinity.
423. Id.
424. In the face of conservative patterns of care, it is reported that "young professionals exert a fierce pressure for legal and financial approval of new types of care." CARE IN THE NETHERLANDS, supra note 371, at 38.
425. Linde, supra note 422.
426. P.J. Bloemestijn, supra note 375.
(4) lack of legal guarantees for physical access to buildings; and

(5) insufficient attention in general health, labor, education, and social welfare legislation to the specific problems of rehabilitation.\textsuperscript{427}

Government and consumer spokesmen seem to agree on basic reform principles.\textsuperscript{428} In revising policy and legislation, Blommestijn urges that "we ought to involve the handicapped in our planning activities."\textsuperscript{429} He views Dutch society as "not accessible in a sufficient degree to handicapped persons in different respects."\textsuperscript{430} To counteract that tendency, he believes an "official code is needed or an act of an educational nature for the promotion of accessibility of public life for handicapped persons."\textsuperscript{431} In changing legislation and the delivery of services, the "leading principle should be that living in the community, in familiar surroundings, is preferable above institutional care."

Leaders in the profession, such as Jan Meiresonne, expressed many similar views.\textsuperscript{432} In addition, Meiresonne has described the lack of "satisfactory regulation of legal rights," as "an obvious gap" in Dutch services for the retarded.\textsuperscript{433} He also drew attention to contractual relationships as a means of improving developmental services and increasing consumer participation. In the context of residential admissions, the retarded person, his representative, and program managers would agree on the training plans, goals, and components.\textsuperscript{434} The problem Meiresonne posits is a lack of channels for such shared decisionmaking in most residential institutions and undue reliance on fictive consents.\textsuperscript{435} To cope with the problem he has advocated the contract model.

\textsuperscript{427} Interview with P.J. Blommestijn at The Hague (Mar. 28, 1974).


\textsuperscript{429} Interview with P.J. Blommestijn at The Hague (Mar. 28, 1974).

\textsuperscript{430} Id.

\textsuperscript{431} Id.

\textsuperscript{432} Blommestijn, supra note 375, c. IV, at 5-6.

\textsuperscript{433} For additional extracts of the Meiresonne interview of March 27, 1974, see notes 449-56 and accompanying text, \textit{infra}.

\textsuperscript{434} \textit{CARE IN THE NETHERLANDS}, supra note 371, at 38.

\textsuperscript{435} Interview with Jan Meiresonne in Utrecht (Mar. 27, 1974).

\textsuperscript{436} Id. Mr. Meiresonne explained:

If a mentally retarded person is referred by professionals or others for residential care, that is to say where there is an indication of [his] going to a residential facility and living there, in coming there it may be that he is not enough aware of what is going to happen.

In that situation, juridically seen \textit{i.e. from a legal point of view}, it cannot be said that there is a full power to accept and agree \textit{i.e. consent} with the situation. Juridically seen, there is a lack of agreement. You ought to have, say on one side of the agreement the retarded person, if in majority,
I think there must either be a real contract between the retarded person himself and the institution, or a situation in which the guardian in cooperation with the mentally retarded person can officially make the contract and can officially be responsible for that, and can also ask for [the retarded person's] response to what they are doing . . . . In many situations, even the institutionalized mentally retarded person has more responsibility, more capacity for doing some things than is expected.\(^{437}\)

The contract concept, in both its practical and symbolic aspects, can increase respect for the rights and dignity of the individual resident. Contract principles have often been overlooked as a means of setting standards and maintaining accountability.\(^{438}\) So far the idea has been well received in Holland. National organizations of parents and the national associations for residential care hope to negotiate general framework contracts of national application, to be supplemented by individualized contract terms between the mentally retarded person or his legal representative or trustee and the facility concerned.\(^{439}\)

The Netherlands faces a number of overdue legislative issues affecting mental retardation. An estimated 500 retarded persons are placed under the civil commitment law of 1884.\(^{440}\) Should the mentally retarded person be subject to compulsory detention? More generally, does the retarded person have the means to claim the benefits due him?

The Dutch system is commendably generous and broad in scope.\(^{441}\) Yet for the retarded to gain full use of the system, that system would seem to require new forms of advocacy, representation, or citizens' advice services. Obtaining statutory benefits would not be limited to families who know and can manipulate poorly codified welfare laws and regulations. Limited guardianship and advocacy provisions for seriously disabled persons remain an urgent priority. Such reform provisions could cover institutional

\(^{437}\) Id.


\(^{439}\) Letter from Jan Meiresonne to author (July 14, 1976).

\(^{440}\) Interview with P.J. Bloomstijn in Utrecht (Mar. 28, 1974).

\(^{441}\) See notes 390-96 and accompanying text, \textit{supra}.
residents without familial protection who need an appointed guardian or visitor.

Legislation in the Netherlands may contribute to an imbalance between institutional and community-based services. Over the last decade or more, there has been a rapid and unprecedented growth in the number of beds in residential institutions for the mentally retarded. In contrast, the number of special schools for the mentally retarded over that same period barely increased. Similarly, admissions of retarded persons to day care centers and hostels increased less rapidly than admissions to institutions.

The Exceptional Medical Expenses (Compensation) Act, popularly known as AWBZ, may promote these disparities. The Act, from the first day of admission onward, pays for treatment and nursing in recognized institutions for the mentally retarded, medical children's homes and nurseries, and institutions for the blind and the deaf. In terms of public expenditures, the AWBZ is one of the fastest growing forms of national social insurance, with total benefits reaching 2.56 billion guilders in 1973 (up from 1.51 billion in 1971). This form of fiscal support does not now extend to day care, hence community care for the retarded grows more slowly.

This funding pattern, in Blommestijn's view, poses a "serious" lesson to all legislators. With expenses entirely paid from the first day of admission, residential or medically-oriented care has the longest waiting lists. "More and more people are inclined to apply for care in those institutions that are approved by this Act." As a consequence, domiciliary care and other nonmedical and nonresidential alternatives are not as readily available.

442. In 1963 there were 33 institutions serving 11,200 patients. By 1972 there were 113 institutions with 20,610 beds. DUTCH SERVICES, supra note 373.
443. Id. The number of special schools increased from 349 to 398 and enrollment increased by 5%.
444. Id. In contrast, only 5,000 retarded persons were in centers and 2,600 were in hostels in 1972.
447. Blommestijn, supra note 375, c. I, at 3. According to Blommestijn: For the time being, aid given under the A.W.B.Z. is—with some exceptions—limited to what is referred to as intramural nursing, which means treatment and nursing within the walls of an institution. The possibility that benefits will eventually be extended to include assistance given outside an institution (extramural or ambulant care) is not entirely ruled out, but it is a matter that will take some time to settle.
448. Id. Summary Statement at 3.
D. Implementation of the United Nations Declaration

Mr. Jan B. Meiresonne, the N.O.Z. Executive Director, provided an appraisal and rating of Dutch implementation of the 1971 United Nations Declaration. At the outset, Mr. Meiresonne stated that existing laws in the Netherlands concerning the retarded were "generally in correspondence with the content of the rights of the United Nations Declaration." He noted that the Declaration was translated in Dutch and was well known to parents, professionals, administrators, and organizations working in this field. The Declaration has been cited in Dutch periodicals and its specific provisions have been used as a starting point in assessing services and arguing for improvements.

1. Article I: Equal Rights

Respect for the retarded person's equality of rights was rated "very good to excellent." In legal or regulatory terms, provisions for social services do not exclude the retarded. Mentally retarded people in the Netherlands are accepted as people and as citizens with the laws of that society being applied to them. "Given this public acceptance," Meiresonne concluded, "it has not been found specifically necessary to point out special rights because general rights applied."

2. Article 2: Developmental Services

Compliance was rated "good to very good" with regard to both legal principles and their application. Dutch legislation provides these services through various laws administered by several ministries. These include laws on special education, regulations on the quality of care in residential facilities, and regulations on group homes and day care. This framework also provides help to families caring for their own members at home.

449. In interviews on March 26-27, 1974 in Utrecht and on September 16, 1975 in Dublin, Mr. Meiresonne graciously responded to the author's questionnaire and many queries. As a lawyer, Director of N.O.Z., Secretary of its Commission on the Rights of Handicapped Persons, and an officer of the International Association for Scientific Study of Mental Deficiency (IASSMD), Mr. Meiresonne was a uniquely qualified and knowledgeable respondent.

450. Mr. Meiresonne stated that "at this point, all mentally retarded people in the Netherlands are considered as people in society, and there is no objection to the rights of all people being applied to them."

451. According to Meiresonne, in some rural villages retarded persons are "a little bit separated from society," a tendency strongly criticized in the press.
3. Article III: Economic Security and Work

Implementation of income maintenance provisions was seen as “good to very good.”* Article III: Economic Security and Work

There are, in Meiresonne's words, a “complex of laws guaranteeing several kinds of material assistance,” including social insurance and general assistance laws. Regulations for sheltered employment guarantee a wage for those disabled persons capable of performing within one-third of normal production.*

4. Article IV: Home and Community Life

The promise of article IV was regarded as having “come into practice in the Netherlands.”* Compliance is viewed as “good to very good.” While there are few foster care programs at the moment, the Dutch, “inspired by international activities and programs,” hope to promote a more methodical development of fostering programs. Social integration, particularly in recreation programs of the Ministry of Culture, is seen as increasing.

5. Article VI: Legal Protection

Mr. Meiresonne found article VI, legal protection, difficult to evaluate because of its broad language and his insufficient knowledge of day-to-day court activities.* He attributed the absence of maltreatment cases to the nonprofit basis of residential care and the “positive attitude toward the mentally retarded and concern for their well-being in the family sphere and by others who look to their well-being.”

6. Articles V and VII: Guardians and Procedural Safeguards

Dutch law on guardianship and incompetency procedures is viewed by N.O.Z. as unsatisfactory. New legislation has been proposed to pro-

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* See note 395 & accompanying text, supra. The Netherlands has the distinction of pioneering sheltered work for the retarded and maintaining a leading international position in this field. See R. Sterner, supra note 4, at 28.

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* According to Mr. Meiresonne, “[i]t is well accepted that the retarded person has the right to live in his own family, or in foster parent's home, or in special facilities.”

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* If any mentally retarded person must come to court for any [criminal] accusation, as every other person, he has a right to a defence counsel, and he will get it. Either the person himself, his family, or professionals will see that a lawyer is appointed for him, and this is well accepted here.

In Meiresonne's opinion, abuse or degrading treatment of any retarded person would be dealt with under the general criminal and negligence laws.
vide guardianship) for severely retarded adults and others, and mentorship for the less severely impaired. Existing guardianship provisions are limited to minors and guardianship of the property of adults. Repeal of the civil commitment laws is also sought, since its defects, inter alia, include linking institutionalization with forfeiture of rights.

E. Summary

In providing for the disabled, the Dutch have made notable achievements in educational, vocational, and social spheres. Although quick to acknowledge deficiencies, interviewees pointed with pride to important legislative bases for greater social integration of the disabled. In their view, Dutch mental retardation services were in a process of transition, a process aiming at more systematic coordination, integration, planning, and human rights protection. New initiatives to strengthen and extend those rights are now under consideration. The government, for example, is reviewing amendments of laws on civil commitment and guardianship of the person. It is working on a simplification and recodification of social security provisions, on elimination of barriers to physical access, and on programs of early detection and treatment of disabilities. Organizations for the disabled are pressing for advocacy programs, the contract model of care, a unified inspectorate for care facilities, and safeguards for the friendless retarded child or adult. Out of these initiatives and proposals, the Dutch hope to add new legal and administrative safeguards to an already formidable legacy of human rights accomplishment.

VI. DENMARK: TOWARD INTEGRATION AND NORMALIZATION

Denmark is moving toward a decentralized structure in which the retarded receive services which are part of a general social welfare system. Danish

456. "But we do not have a guardianship of the person," Mr. Meiresonne has said, "so we want a flexible one, not just for the mentally retarded, but for all other impaired persons, including psychiatric patients."

457. Under general legislation, all persons in their minority are entitled to the guardianship of their parents, or an appointed guardian (either an individual or guardianship agency). As adults, the "curatelle," a plenary guardianship concerning property and restricting all kinds of activity, is the only form of guardianship now available.

458. Under the Act of 1884, a mentally disordered person can be court-committed on the public attorney's petition, separated from society, and "automatically lose their rights."

459. Most of these proposals were still pending at the time of the author's request for updated information. For example, the recodification, termed a "Framework Act for the Social Service System," is not expected for "some time." Letter from Jan Meiresonne to author (July 14, 1976).

460. Mental retardation services are administered by 10 regional authorities. They are under the general supervision of the Board of Social Welfare and its section on Re-
leaders express a passionate commitment to normalization and its concrete expression in equal rights for the retarded. By fostering openness in decisionmaking and encouraging consumer participation, these professional leaders have mobilized an effective coalition for reform.

A. National Legislation

Danish services for the mentally retarded are in the process of legal and administrative reorganization.461 Since 1959, the Act Concerning the Care of the Mentally Retarded and Other Exceptionally Retarded Persons (hereinafter "the Act") has authorized special care, education, vocational training, and guardianship services.462 A special National Service for the Retarded, within the National Board of Social Welfare and under the auspices of the Ministry of Social Affairs, administers these provisions.463 The National Service receives guidance from national and regional advisory councils whose members, by law, must include parent representatives.

Some 22,000 persons (4.5 per 1000 of the population) are registered as clients of the National Service. Financed by the national government, the Service includes a range of clients affected by mental handicaps, including retarded, blind, deaf, motor-handicapped, epileptic, brain-injured, psychotic, emotionally disturbed, language-handicapped and "other exceptionally retarded persons."464


462. The Act No. 192 of June 1959, concerning the Care of the Mentally Retarded and Other Exceptionally Retarded Persons, as amended by Act No. 228 of May 27, 1970, concerning Service Administration [hereinafter The Act].

463. See GENERAL SURVEY, supra note 461, at 8. The Act of 1959 requires periodic review of the continued necessity of special services for the retarded individual, ch. II, § 6(3); and a structure of independent tribunals to review "decisions as to the initiation and termination of relief measures." Ch. I, § 4.

464. GENERAL SURVEY, supra note 461, at 10. The basic eligibility provision of the 1959 Act states:

Entitled to receive help and assistance from the Service are those who are
The 1959 Act was, in large part, a reaction to the medical model. In the place of large institutions led by physicians as administrators, the Act encouraged the development of small living units and day services under multidisciplinary leadership. In 1959, administrative responsibility for all services within each region devolved to a team consisting of a chief physician, a director of education, a director of social work, and a business administrator. The declared purpose of the 1959 Act was "to create an existence for the mentally retarded as close to normal living conditions as possible." That aim remains the keystone of Danish planning for future services.

1. Normalization

Normalization has become shorthand for the principle expressed in both the 1959 Act and in the 1971 United Nations Declaration. To Mr. N.E. Bank-Mikkelsen, one of the Act's framers and Director of the Danish

mentally retarded or whose state may be considered as ranking with mental retardation, and who may be estimated to be in need of provisions for care.
The Act No. 192, ch. II, § 5. A national register of clients of the mental retardation service showed a rate of 4.5 clients per 1000 of the total population. Of a total number of 22,127 clients served, 9,492 were in residential care, 7,136 were in nonresidential care (schools and workshops) and 6,265 were receiving other services in their home (economic support, treatment, or social worker visits). Danish Nat'l Bd. of Social Welfare, Institutions and Clients of the Mental Retardation Service, 1973 (unpublished statistics, Copenhagen).

Reform was difficult. On the one hand, a system which the experts in principle considered satisfactory had to be broken down; and on the other hand, a completely different system had to be built up.
Id. at 243.
466. Id. at 244.
467. On formulations of the principle, see notes 53, 86 and text accompanying note 466, supra.
National Service for the Retarded from 1959 to 1971, the principle of normalization "simply means that all citizens shall have equal access to the same benefits." More narrowly stated,

[n]ormalization means making normal mentally retarded people's housing, education, working, and leisure conditions. It means bringing them the legal and human rights of all other citizens. Applying that principle in Denmark has led to a reexamination of older protectionist philosophies. It has led to a slight decrease in the proportion of the Danish population who are clients of residential facilities. It produced, and is still producing, fundamental reorientations of professional responsibilities to clients.

How far can normalization be applied in law and in practice? To Bank-Mikkelsen, the Danish and United Nations formulations of that concept should now "go further." He has recommended deleting the words "as close as possible to normal life," and speaking only about "normal life." Some retarded persons, however, may lack certain capabilities for ordinary living. They may require levels of service and care beyond those generally afforded their age peers. Bank-Mikkelsen analogizes such special needs to ordinary and special medical treatments for diseases and disabilities to which all citizens are entitled under national health insurance programs. Since the mentally retarded share those needs, "it is consonant with the normalization principle that mentally retarded persons" should be offered specialist treatment. Treatment, Bank-Mikkelsen hastens to add, is not definitionally limited to physical or medical treatment, but also "comprises special education." Within a framework of services based on need, the mentally retarded and other handicapped people would have "a right to special education or special treatment."

2. Integration

In a society in which health, rehabilitation, and education services are universally available, the need for separate services for the retarded can be questioned. "In the near future," Bank-Mikkelsen asserts, "Denmark will

469. The Principle, supra note 468, at 9.
471. Id. at 250. In the period between 1958 and 1974 the actual decrease in the rate of client institutionalizations was from 2.0 to 1.8 per 1000 population. The total number of clients in residential facilities, 9,497 in 1974, has changed little.
472. See note 460, supra.
474. Id. at 4.
show that no special service is needed to take care of the mentally retarded."

Long term planning of Danish services emphasizes twin goals. As children, mentally retarded persons should stay with their parents as long as possible. As adults, mentally retarded clients should live as independently as possible in homes of their own (i.e. in apartments, collective living facilities, or in the protected homes provided by society). Over the next dozen years, this means reducing "the big old institutions and eventually doing away with them," by providing small living units with no more than 20 to 25 places.477

In a broad reorganization of Danish social services, regional mental retardation services are now under the central control and coordination of a unified National Board of Social Welfare. This reform is intended to reduce the need for, and negative consequences of labelling. It is also seen as furthering integration and decentralization of the administrative responsibility for statutory services.478 The new integrated social services system is to be "based on equal rights to help not according to the name of the handicap, but according to the nature of the needs, such as the need for education and training, money, sheltered employment, help at home, etc."479 However, a decentralized system, as Bank-Mikkelsen acknowledged, implies the risks of disparate and unequal services in different parts of the country.480

B. Enforcing Rights

Those risks of unequal services and unequal burdens already impinge on the Danish retarded. For over two decades, the National Association of Parents (Landsforeningen Evnesvages Vel) [LEV] has called for better legal protection of retarded individuals. In 1953, LEV requested the Minister of Social Affairs to form a committee to address that and other

476. Id. This statement appears to refer to special administrative arrangements, rather than to special services of education and treatment. Those services, Bank-Mikkelsen points out, "should be provided according to need and not merely because [the clients] are mentally handicapped." Bank-Mikkelsen, supra note 460.
478. Ideology and Practice in Labelling and Registration, supra note 468.
479. Id. at 8. Procedural safeguards would still accompany the initiation and periodic review of those services. According to Bank-Mikkelsen:

As long as the very fact of being mentally retarded is accompanied by negative effects on civil rights, which means, as long as a mentally retarded person is not given all civil rights, it is justified to surround registration with safety measures as a guarantee against misuse.

Id. at 4.
problems, including "juridical control of all those involuntarily placed in institutions, the right to complain," and guardianship arrangements. As more fully explained in section C, these reforms have only been partially accomplished.

The 1959 Act has been a major step in improving services and fostering equality under law. It amended, but did not repeal very restrictive legislation detaining mentally retarded persons. It replaced a system in which psychiatrists were criticized for prolonged and groundless detentions of clients with a system "based almost entirely on the principle of voluntary use of services." In all this the courts had a role, but they have not been a factor in recent years. In 1954, the Danish Constitution was amended to conform with the European Convention on Human and Civil Rights. One of the adopted amendments guarantees that the commitment and detention of mentally retarded persons by administrative authorities can be challenged in the ordinary courts. Through cases of administrative detention and by limiting the numbers of people sentenced to retardation institutions, the courts are described as having had "a reasonable significance.

Notwithstanding improvements since 1959, Danes recognize that many essential reforms remain incomplete. There is still discrimination pertaining to the right to marry and the right to an education. There are still dormitory wards with up to 30 beds in a room. And over half of all clients of residential services live in institutions housing 600 or more people.

481. Id. at 247.
482. See text accompanying notes 492-522, infra.
483. The mentally retarded, for example, can be detained if considered dangerous to themselves or others, or if after release are likely to "be a considerable nuisance to themselves." According to Bank-Mikkelsen:

Even these decisions may soon be brought under the control of the courts and we hope that there will soon be equality between mentally retarded citizens and others even here.

Bank-Mikkelsen, supra note 460, at 244.

484. Id. But see note 483, supra, and The Act of 1959, supra note 462, ch. IV, § 10 (judgment of dangerousness to be made by chief physician).

485. The Constitution of Denmark, ch. 8, § 71(b) (1953). Compare Denmark's amendment of its national laws to conform with the European Council's Convention on Human Rights, with Great Britain's response. See note 299, supra, and Bank-Mikkelsen, supra note 460, at 244.

486. Id. at 246.
487. See text accompanying notes 493-94, infra.
488. See text accompanying notes 495-502, infra.
489. See R. STERNER, supra note 4, at 54. The average number of beds per residential sleeping room, 2.7, is low by international comparison.

490. Id. at 53.
In Denmark, the Parents' Association (LEV), mindful of past progress and involved in present and future planning, anticipates positive changes. This optimism is founded on the excellent collaborative arrangements between the Association and service-providing authorities. LEV participates in service planning on a regular basis and has an officially recognized role as a bargaining agent for the retarded. Mr. John Møller, as spokesman for the Danish Parents' Association, termed this collaboration "a new and revolutionary thing." It stemmed from the Act of 1959 which "stated that the parents and relatives of the mentally retarded should directly take part in the leadership of the service." LEV's leadership role was prescribed at the national board level of the National Service for the Mentally Retarded and in "the board of inspectors" set up in each of Denmark's 11 regions. Under the 1970 Reorganization Act, integrating mental retardation services with other child, youth welfare, and rehabilitation services, the Association retains its participatory role, with two representatives on both the National Advisory Board and the regional advisory boards.

C. Implementation of the United Nations Declaration

John Møller, a parent member of the Copenhagen Advisory Board and LEV's Central Board, and Borge Olsen, manager of LEV, reviewed Danish progress against the background of the United Nations' 1971 Declaration.492

1. Article I: Equal Rights

Under Danish law, according to LEV's representatives, there is no difference between the mentally retarded and other citizens. National legislation is seen as providing "the same rights for all." In their view, national statutes "definitely go further" than do the principles of the United Nations Declaration.493

Existing law still imposes a restriction on mentally retarded and mentally ill persons marrying without special permission from the Ministry of Justice. This rule, first enacted in 1922 and extended in 1938, has been criticized by a governmental commission as discriminatory. The commission recommend-
ed equality between mentally retarded persons and others, and abolition of the restriction. The commission showed that denying permission had not prevented couples from marrying, living together, and having children; that some couples may have cohabited without being married to avoid the humiliating application procedures; and that "many positive effects of marriage were demonstrated in cases where marriage was not allowed."\footnote{494}

2. Article II: Developmental Services

In 1971, 3,000 children were reported as excluded from schooling because of official determinations that they could not benefit from education and could be exempted from compulsory education.\footnote{495} Under section 9 of the 1959 Act, the mentally retarded child is "subject to compulsory education" from the ages of 7 to 21. A wide variety of provisions for education, training, and general development may fulfill this requirement. The mode of education must, however, "not conflict with the interest of the person in question."\footnote{496}

At interviews held in 1974, LEV and National Board members spoke of insufficient education or training, or the complete lack thereof for many of the more severely handicapped.\footnote{497} In 1976, it was still reported that some mentally retarded receive no education even though "they have a specific right to this."\footnote{498} LEV is campaigning to place the education of all retarded persons under the Ministry of Education. Some educators, reluctant to include the profoundly and severely retarded child within their responsibilities, resist this change. LEV feels that a transfer of administrative responsibility would (1) overcome this resistance, (2) thereby insure that "schools would be free for all," and (3) make available for the Social Welfare Board’s activities monies now apportioned for education.


\footnote{495}{Bank-Mikkelsen, \textit{supra} note 460, at 247-48.}

\footnote{496}{The Act No. 192, ch. III, § 9(4). Decisions on compulsory education and training can be questioned by the client or "one who acts on his behalf" before the "central tribunal for settlement." \textit{Id.} § 9(5). The Central Tribunal is empowered to hear a broad range of complaints respecting compulsory measures or the initiation or termination of "relief measures." The Tribunal is established by the Minister of Social Affairs and is composed of a chairman with the qualifications prescribed for a high court judge, a social trainee and an expert in psychiatry, "who is independent of the [Mental Retardation] service." The Act, ch. I, § 4(1).}

\footnote{497}{Interview with John Møller and Borge Olsen in Copenhagen (Apr. 2, 1974).}

\footnote{498}{Bank-Mikkelsen, \textit{supra} note 460, at 245, 249-50.}
The cause of these exclusions of the retarded from education has been variously attributed to a lack of money, an exemption under a “benefit from education” legal clause, and inconsistent administrative interpretations. Educational provisions for the retarded in Denmark, Bank-Mikkelsen explained, should have no exceptions.\footnote{According to Bank-Mikkelsen in a panel discussion on September 1973, at the Third World Congress Int’l Ass’n for the Scientific Study of Mental Deficiency at The Hague:}

\textit{We know now that all children can be taught, and it must be the duty of every country to extend an offer of teaching to all children, irrespective of their mental development. It must be considered a human right to have access to education.}

\textit{The Principle, supra note 468, at 8.} 

Yet, according to a 1976 report, about 3,000 children receive only very inadequate education or training, or none at all because of insufficient resources.\footnote{Interview with K. Gynther Nielsen (attorney) and Leif Vind (educational consultant) in Copenhagen (Apr. 3, 1974).} The 14-year compulsory education period for the retarded is far longer than that for normal youth.\footnote{See R. STERNER, supra note 4, at 52.} To this extent, there is some discrimination, albeit protective or otherwise, compared to the nonretarded. Subsection 8(5) of the 1959 Act does provide some opportunity for review by a central tribunal of compulsory education decisions.

3. Article III: Economic Security and Work

Disability pensions are available to retarded persons 15 years of age or older with impaired work capacity. Parents with a retarded child under 15 living at home are entitled to allowances for extra costs due to the handicap. Although retarded adults in principle have opportunities for remunerative work,\footnote{The Act, ch. III, § 9(2).} there is a shortage of sheltered workshop places and related facilities.

4. Article IV: Home and Community Life

Besides the allowance for extra expenses attributable to the child’s

\footnote{The Principle, supra note 468, at 8. Bank-Mikkelsen has written:}

Mentally retarded adults ought to have the same right to work and pay as other citizens. This often presupposes that they must be given preliminary vocational training, but many years experience goes to prove that mentally handicapped, even severely handicapped, can be trained to work in modern industries to mutual enjoyment and benefit for themselves and their community.

\textit{Id.}
handicap, parents caring for children at home are entitled to a variety of
counselling, respite care, and other domicilliary aids. 504

Although the Parents' Association did limit some hiring freezes on residen-
tial care staff, budgetary limitations have caused some cutbacks in once
universally available habilitation programs, and have slowed the movement
of retarded residents from larger to smaller residences. 505 In residential units,
LEV representatives visit some two to three times per week and help see to
it that every resident gets some attention and is "not put away in a
room." 506

One institution for the retarded has more than 1200 beds, while half of
those in residential care were in institutions with over 600 beds. 507 The
National Board of Social Welfare and LEV are campaigning to reduce
institutional populations, increase the number of integrated group homes,
and create year round educational opportunities to occupy residents in the
summer and other periods. With 10 percent of residents living in dormitories
for 10 or more persons, LEV spokesmen feel there is much to do. The
state provides mentally retarded persons with residential services, medical
and dental care, and education and training free of charge. 508

5. Article V: Guardians

Guardianship services are regarded as unsatisfactory. Mr. Møller and
Mr. Olsen spoke of parental dissatisfaction with guardianship, which is
performed by local politicians, is largely pro forma, and involves 30 or
more wards per guardian. Furthermore, according to Mr. Møller, some
parents are too protective, initiating guardianship provisions "without rea-
son." Under Danish law, the staff of agencies rendering direct services are

504. For a detailed description, see Shearer, Paper 3, in QUALITY
OF CARE, supra note 461, at 29-42.
505. See R. STERNER, supra note 4, at 53-54. According to Sterner, "[t]here used to
be programmes (training, education, work, leisure time activities) for virtually all resi-
dents, which is very unusual but, because of budgetary limitations, this is not entirely
true today." Id.
506. Interview with John Møller, supra note 492. Representatives are elected by other
parents with children on the unit. See Danish Nat'l Serv. for the Mentally Ret-
tarded, Circular Letter No. 27 "On Cooperation Between Parents (relatives), Clients
and the Service for the Mentally Retarded," Sept. 27, 1971. On each service unit, a
"joint council" is established of parents, staff, and those clients over the age of 18 "who
are able to be partners in cooperation." Representatives may bring up in joint council
meetings such topics as the "clients' everyday routine," initiation of "activities for clients
. . . without any next-of-kin," holiday arrangements and excursions, etc. Id. at 12.
507. See R. STERNER, supra note 4, at 53.
508. Id. at 52-54.
barred from being appointed guardians to service clients. Recruiting qualified guardians is a problem, and there are no special representatives for children without familial protection. The LEV representatives to units or departments, according to Møller, should be aware of such children and look out for their interests.

A valuable feature of Danish law is the power to appoint a guardian for detained persons. Under the 1959 Act, the probate court on a motion by the National Service can appoint a guardian at the time of proceedings to commit an adult "as dangerous for himself or other people," or to extend compulsory education and training for an adolescent.

6. Article VI: Legal Protection

The National Board of Social Welfare receives and responds to service complaints from individual clients, or their families and friends. The Ombudsman has also issued some rulings concerning mental retardation care. One case resulted in guidelines for speedy processing of complaints. The National Board is required to give prompt notification to a complainant of its decision. In more involved cases it is to advise complainants when a decision can be expected.

509. The Act, supra note 462, ch. IV, § 12(3) provides:
   The guardian has to keep himself informed of the condition of the mentally [retarded] persons and to see that relief measures be not upheld for a longer period than necessary.

510. Interview with K. Gyntner Nielsen in Copenhagen (Apr. 3, 1974). For example, in one recent year 53 complaints from clients and/or relatives were brought before the complaints meetings of the National Social Welfare Board [Socialstyrelsen]. Sager der har varet på Klage mod fra oktober 1972—oktober 1973: Klager fra klienter, parstrøede m.v. (items before the complaint meeting, unpublished Board memorandum). In these cases, the Board's staff lawyer will investigate. On pain of disciplinary action, any staff member observing an assault or serious incident is under a duty to inform the facility and the Board of Social Welfare. In cases of suspected assault, a special committee is convened. Composed of representatives from the Care Department, Child and Youth Department, and Personnel, it meets to investigate the case and to decide what action to take (warnings, firings, etc.).


   I would have required that the Board in handling the case at an earlier stage would have given Mrs. Albrechtsens [the complainant social worker] a preliminary answer in what you are doing in this case, and if possible when she
Even with these administrative reviews, there are still flaws in the protection of legal and human rights. While some have already been mentioned, or are referred to in the discussion of incompetency proceedings, there are others. The criteria for discharge from civil commitment are vague—mentally retarded persons can be detained “who may, after release, be a considerable nuisance to themselves.”\(^{513}\) Bank-Mikkelsen has predicted that these decisions of compulsory civil admissions and detention “may soon be brought under control of the courts.”\(^{514}\) While sterilization has now been placed on a voluntary basis, there are still great problems about the procedure for this and other aspects of “the right to sexuality.”\(^{515}\)

The Parents’ Association puts great reliance on informal approaches and public relations to redress complaints. At the ministerial, board, and local levels, LEV representatives are said to make productive use of “open door” policies and good working relations. To Mr. Møller, who estimated that each year LEV places 8-10 complaints before the Minister of Social Affairs, a lack of formal procedure for handling complaints is “not missed.”\(^{516}\) As the legal negotiating or “collective bargaining” agent for consumer interests, LEV is satisfied that this legal status, coupled with informal procedures, produces good results.

7. Article VII: Procedural Safeguards

Under the 1959 Act, the National Service is to advise the courts of the desirability of appointing “a qualified and willing guardian” for its clients.\(^{517}\) This recommendation can be made when other compulsory measures have been initiated,\(^{518}\) the mentally retarded person personally requests such an appointment, or “it is otherwise so indicated by the circumstances.”\(^{519}\) As previously mentioned, LEV finds these arrangements unsatisfactory.

\(^{513}\) Bank-Mikkelsen, \textit{supra} note 460, at 244.
\(^{514}\) \textit{Id.} For elaboration, see note 483, \textit{supra}.
\(^{515}\) Bank-Mikkelsen, \textit{supra} note 460, at 247. \textit{See also} notes 494, \textit{supra} and 522, \textit{infra}.
\(^{516}\) Interview with Møller, \textit{supra} note 492. But consider the Central Tribunal, \textit{supra} note 496.
\(^{517}\) The Act, \textit{supra} note 462 ch. IV, § 12(1). In making that appointment, “[u]nless circumstances prevent, the wish of the person in question should be taken into consideration. . . .”
\(^{518}\) \textit{Id.} \textit{See also} ch. III, § 9(3). \textit{See text accompanying note 509, supra}.
\(^{519}\) \textit{Id.}, ch. IV, § 12(2).
Circular Letter Number 21 of the National Service allocated professional responsibility for the making of recommendations for appointment of guardians, declarations of personal incapacity, petitions for sterilization, "petition for castration," and placement in a closed ward.\textsuperscript{520} Under this directive, the medical executive has considerable authority, either in consultation with the social and educational executives or otherwise, to initiate petitions leading to drastic restriction of rights.\textsuperscript{521} But under the Mentally Disturbed and Subnormal Persons Act and the Criminal Justice Act, the unit chief was made responsible for initiating and recommending guardianships.\textsuperscript{522} Based on available information, these provisions did not appear to be in accord with either the letter or the spirit of the United Nations Declaration.

\textbf{D. Summary}

New attitudes must often accompany new legislation. The 1959 legislation aimed at giving the retarded person a life as normal as possible. Not all people accepted this goal, however, and old-fashioned attitudes frustrated change. Part of that problem, according to Bank-Mikkelsen, was generational and caused the National Service Director to think of "replacing old leaders—on all levels—who did not want change, even though they may understand the new concepts."\textsuperscript{523} Part of the problem was one of resources and political will to transform the goals of the United Nations Declaration into reality.

Even after reordering priorities, the mentally retarded "still turn out last in the queue."\textsuperscript{524} In Denmark and elsewhere, Bank-Mikkelsen has urged that this fact of inequality spur the struggle for civil and human rights for every

\textsuperscript{520} See Danish Nat'l Serv. for the Mentally Retarded, Circular No. 21, "to all Regional Centres on such allocations of responsibility and authority among the centre executives as shall apply for the time being," Jan. 21, 1969, at 15-16 (Copenhagen).

\textsuperscript{521} Id. at 16.

\textsuperscript{522} Id. at 16, 1. The unit chief is referred to as the "primarily responsible centre executive." Act. No. 318 on Sterilization and Castration, June 13, 1973, places on the petitioner the burden of establishing the need for such an operation. While voluntary in form, the Act is not clear as to whether or not third parties can get such a petition in motion for a retarded person.

\textsuperscript{523} Activities of Daily Living, supra note 468, at 4.

\textsuperscript{524} The problems, as Bank-Mikkelsen explained, are of attitudes, not just institutions.

Countries which formerly merely protected or segregated their mentally retarded citizens in ghettos of hopelessness are today breaking up their old, unsuitable institutions and are now starting to erect more suitable houses for their handicapped citizens. Developing countries must avoid those [earlier] mistakes. . . .

Vocational Rehabilitation of the Mentally Retarded, supra note 468, at 3.
person. Without that struggle, he sees little likelihood of turning paper declarations into realized rights.525

Denmark continues to recognize the human rights implications of normalization. Leaders of its retardation services are also aware that shortcomings in those services must be exposed to public scrutiny. "We must open our institutions to criticism of the press, radio and television," wrote Bank-Mikkelsen.526 Involving the public in this monitoring helps point the way to more humane and sensible alternatives. By bringing parents and their associations into this process, the Danes show that public vigilance can erode old restrictive laws and attitudes.

VII. TOWARD ENFORCEABLE HUMAN RIGHTS

A. Summary of Findings

1. Protecting Individual Rights

Without compliance machinery, human rights declarations may only highlight the distance between promise and practice. The incantation of rights alone works no magic, particularly in view of the retarded person's frequent inability to know or assert his rights. Moreover, the public has its own deficiencies in knowledge. Some people deny that human rights have application or value to these "different" people. Hence people of limited intelligence suffer not only handicaps inflicted by nature, but those imposed by man: prejudice, neglect, debasement, isolation, and indifference. To offset these handicaps, persons with substantial intellectual deficits require advocates and other agents to interpret, monitor, and assert their rights.527

This problem is one of international scope. Even if policies in this field were always sound and professional practices always enlightened (and they are not), the mentally retarded person would have more than his share of personal conflicts and legal problems, given the societal and governmental pressures impinging upon him. But it is not enough to say that the public must first change its attitudes before cruel discrimination can be outlawed. It is not enough to say that the branches of government should be open to hear

525. The Quality of Care, supra note 461, at 18:
The time of charity is over. Their rights are embodied in the Declaration of the General and Special Rights of Mentally Retarded adopted by the ILSMH in Jerusalem last year (and now by the UN). These rights up to now, in most countries are only a piece of paper. We will do what is possible to ensure that these rights will be a reality for all mentally retarded in the 70s.


527. For further discussion and documentation, see S. Herr, supra note 20.
of individual rights denied. Without advocates who will seek remedies for
wrongs, the agencies, legislatures, and courthouses are, for all practical
purposes, closed to the retarded. As this article has demonstrated, people of
many nations have become such advocates. The French introduced the
Declaration on the Rights of Mentally Retarded Persons before the United
Nations and the British have gone to court to vindicate parallel rights in
domestic law. The Scandinavians have formed central state agencies to
implement the rights of the retarded, and the Dutch have lobbied for
stronger legal protection of those rights.528

2. Implementing International Principles

The United Nations Declaration on the Rights of Mentally Retarded
Persons is a valuable but only a preliminary step. While none of the
countries surveyed in this article fully satisfies the principles set out in that
Declaration, all have made significant progress. Of some 80 national
leaders interviewed for this article, no one disputed the validity of the
Declaration’s principles and the importance of attaining them. Several
leaders, however, expressed uncertainty as to the application of the more
general articles.529 To reduce that uncertainty and to stimulate government
interest in effectuating the Declaration, much more work at national and
international levels is required.530 The ultimate object of that work is to
speed the day when a separate human rights declaration for the retarded is
no longer needed.

3. Harmonizing National Laws and International Declarations

International declarations are helping to raise human rights expectations
for the disabled of many nations. Through international conferences, meet-
ings, and the exchange of specialists, a climate for change is created. A
major aim of these discussions should be to compare and harmonize national

528. For reference to the multinational membership of the International League of
Societies for the Mentally Handicapped and its Task Group on the Implementation of
Rights, see notes 5 and 46, supra.

529. See statements of Messrs. Everitt, Meiresonne, and Bank-Mikkelsen, supra at
pp. 244, 286, 290.

530. Government officials may be unaware of the 1971 Declaration, or have forgot-
ten it. Like earlier human rights declarations, this United Nations Declaration too is
at the risk of being “shoved back, forgotten, no longer regarded by governments as hav-
ing any application.” Address of Sean MacBride, United Nations Commissioner for
Nambia (1974 Nobel Peace Prize Laureate), to the Conference on International Human
and public action is likely to rescue the disability declarations (see Section II, supra)
from that obscurity.
laws and policies with evolving international standards. For example, the proponents of Sweden's 1976 law on mentorship credited international influences as a key factor in securing reform.531

In the mental retardation field, unlike some disability fields, there is a strong consensus concerning future directions. Translating that general consensus into service planning and legal structures presents greater difficulties. Every country, regardless of its level of economic development, needs such plans and legal frameworks. To formulate them in a way compatible with the United Nations Declaration and with a country's social and legal culture is a difficult and subtle task. Inevitably, the constituency for the rights of the mentally retarded competes with powerful constituencies stressing other national priorities. It often requires persuasive, political, and technical skills of a high order to spare the retarded from harsh utilitarianism.532

4. Evolving Legal Frameworks

Minorities often find in constitutional and statutory law a refuge against majoritarian oppression. The mentally handicapped are no different. Law—for too many years a vehicle for their confinement—may yet be a vehicle for their emancipation. Handicapped children barred from attending school have used courts and legislatures to open school doors.533 Handicapped adults detained unjustly have sought judicial review to lift restrictions upon their freedom.534

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531. See text accompanying note 219, supra.
532. Rawls, for example, maintains that under the principle of redress, greater resources might be spent on the less, rather than on the more intelligent. J. RAWLS, A THEORY OF JUSTICE 100-02 (1972).
533. In recent years, there have been judicial decisions redressing such educational discrimination in Norway and the United States; such court cases have been contemplated in England and Sweden; and corrective legislation has been adopted in England, Scotland, and the United States. For discussion of the legal and social issues raised by this law reform, see Herr, The Right to Education, 32 NEW SOC'Y 409 (May 15, 1975); Kirp, Buss & Kuriloff, Legal Reform of Special Education: Empirical Studies and Procedural Proposals, 62 CAL. L. REV. 40 (1974); Herr, Retarded Children and the Law: Enforcing the Constitutional Rights of the Mentally Retarded, 23 SYRACUSE L. REV. 995, 1002-16 (1972).
Legal reform is no substitute for treating other humans decently or for making the moral, political, and economic commitments which permit decent treatment. Such reform can help, however, to restructure relationships, reallocate benefits, and redefine ideas of what is decent, legitimate treatment.

For analytic purposes, this article sketches three legislative models: civil disability, charitable privilege, and egalitarian. The legislation reviewed in this article reveals an increasing optimism, freedom of choice, and movement toward egalitarianism. The direction of change is toward restructuring rights and services in order to minimize natural inequities and maximize civic equalities between the retarded and all other citizens.

a. Civil Disability Model

The earliest laws recognizing retarded persons stressed social protection and containment. "Idiots" and "imbeciles," viewed as a potentially dangerous and disruptive class, were subject to guardianship, institutional isolation, and other drastic restraints. Incompetency and commitment proceedings were the primary legal devices used. The "ward" or "inmate" could only be found competent or incompetent. An incompetent's personal rights were forfeited, exchanged for the solicitude of the sovereign, exercised through an appointed guardian or institutional warden. The resulting custody was often lifelong, the prognosis "hopeless," and the custodian's power as surrogate decisionmaker unchecked.

b. Charitable Privilege Model

Gradually the ethos of laws concerning the retarded shifted from isolation to benevolence and pity. "Mental subnormals," considered a surplus and inadequate population, were deemed to benefit from bucolic institutional care under medical supervision. Hospitalization procedures and compulsory registration became the preferred legal techniques for exercising coercive control. After a primarily medical examination, the "patient" now could obtain a wider range of services, but only if the law authorized services for the diagnosed disability, a physician characterized the patient as medically fit to absorb the statutory services, and the local authority or charity chose to make them available. If found unfit, the patient depended upon the family's resources and the professional's discretion to forge makeshift arrangements. The resulting treatment varied with social class; the prognosis was a static condition; and the professional's prerogatives were seldom reviewed.
c. **Egalitarian Model**

Civil disability and charitable approaches have given way to a focus on the personal dignity and entitlements of the intellectually disadvantaged. "Persons in need of special services" has replaced the more stigmatizing phrases and epithets. Laws creating and regulating services place greater emphasis on domiciliary assistance and local schools for children and sheltered work settings, occupational centers and small group homes for adults.

Decisions for making those placements are more openly reached. The client, within his capabilities, takes part in planning and exercises options. Major decisions involve multidisciplinary collaboration and periodic review. In those decisions, parents and client representatives, as well as the client, whose wishes can be ascertained by direct or indirect methods, are encouraged to participate.

In an egalitarian model, planning assumes growth and change. Under frameworks of universal education, clients are taught to develop their maximum skills for communication, self-reliance, and autonomy. With greater training, clients can be freed from restrictions and over-protection. This necessitates periodic review of any restriction to ensure it is imposed for the minimum possible duration and causes the least possible hardship. In making these judgments of proportionality, the review panel evaluates the client's need for advocacy then and in the future. If seriously impaired, the client may require the appointment of some advocate, mentor, or guardian. Periodic review should entail assessment of the client's program in meeting program objectives, and the client's response.

The right to complain, without retaliation, is protected. Clients, whenever possible, have freedom to choose. Compulsory powers based on findings of mental retardation per se or staff convenience are abolished. Appropriate regulatory and supervisory agencies perform monitoring, standard setting, quality control, and consultative functions. Substantial departures from basic standards evoke corrective administrative action or, if unexplained or unexcused, some form of judicial or quasi-judicial remedy.

5. **Rethinking Mental Disability Law**

The survey countries are expunging civil disability and charitable privilege approaches from legislation and practice. Sweeping restrictions on the mentally retarded person's rights to vote, marry, procreate, or enjoy other fundamental human freedoms are being called into question. Governmental review of these issues sometimes is triggered by court action. In Britain, for example, a High Court Justice in 1975 ordered court wardship for a mildly
retarded girl threatened with sterilization. Another British court the following year restored the voting rights of persons disenfranchised solely because they lived in institutions for the mentally disordered.

No country with which the author is familiar has yet fully incorporated the principles of the United Nations disability declarations in domestic law, or fully adopted the previously described egalitarian model in practice. While the Scandinavian countries, particularly Sweden, have gone furthest in these directions, even their laws leave individual rights in some jeopardy. In England, the Mental Health Act of 1959, once hailed as a progressive document, is now assailed for its civil liberties deficiencies. In the Netherlands, antiquated guardianship measures and a commitment law adopted in 1884 have been criticized. In Denmark, a law requiring the Justice Department's permission for the retarded to marry is marked for repeal. And in the United States, as recently reported by the President's Committee on Mental Retardation, the mentally retarded person still suffers from the "persistence of past inequities, and the discriminatory restriction of rights."

a. Access to Education

Education and training—starting in infancy and continuing through adulthood—is a central provision in mental retardation laws. Under the laws of England, Denmark, Scotland, Norway, Sweden, the Netherlands, and the United States, to mention but a few countries, there is a right to special education for all handicapped children. All retarded children have this entitlement but a small minority are still deprived of it. Those living in

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535. In re D (a minor), supra note 306.
536. In re Handley, supra note 304.
537. For citation and discussion of those declarations, see Section II, supra notes 52-67.
538. The threat is two-fold: sweeping criteria for restrictions on basic rights and only embryonic systems for advocacy of the disabled person's individual rights. See, e.g., text accompanying notes 143-44 (Sweden) and notes 479 and 483 (Denmark), supra.
539. This is discussed at Section IV, A., supra.
540. See notes 383-84 & accompanying text, supra.
541. See note 494 & accompanying text, supra.
542. CENTURY OF DECISION, supra note 11, at 58.
544. For discussion in national contexts, see Sections III, A.2; IV, C.; V, A.1; VI, C. 2, supra.
large institutions are particularly prone to exclusion from educational services or exposure to qualitatively inadequate services. To facilitate equality of educational opportunity, education laws of England and Scotland transfer responsibility for educating severely retarded persons from health to local education authorities. In Denmark, the Parents' Association seeks a similar transfer and divestiture of medical responsibility. Encouraged by court cases in Norway and the United States, some organizations in Sweden and England are contemplating judicial actions to enforce the retarded child's right to education.

By statute and administrative directive, rights to suitable education and training are granted for very young children and adults above compulsory school attendance age. For retarded adults, this can take the form of vocational training, or, as in Sweden, a wider variety of continued education and training opportunities.

b. Access to Treatment

Safeguarding the fundamental rights of the mentally disabled is more than a problem of involuntary civil commitment. This elementary proposition is often overlooked. The very worst institutions are often crammed with people who are, at least on paper, "voluntary" or "nonobjecting" residents. Most statutory schemes fail to address the problems of these residents and their need for initial and periodic review.

Without such review, access to decent living conditions and community-based habilitation depends more on fortuity than entitlement. Regional variations in care compound this element of chance. The large, isolated, hospital-style institution is often the primary residential resource. These institutions can devour considerable tax monies, while still inflicting the most appalling conditions on helpless residents. Government policy in Britain, Denmark, and Sweden is to relocate institutional populations and to increase care in foster homes, group homes, small residential units, and in retarded persons' own homes. In Sweden and Denmark, state boards, vested with

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545. This transfer is discussed in Section IV, C. and the laws authorizing it are cited at note 543, supra.
546. Discussed at p. 294 supra.
547. See, e.g., note 287, supra.
548. See note 127, supra.
regulatory and supervisory powers, have accelerated implementation of these policies. 550

c. Access to Independent Review

Clients under mental disability laws often lack complaint procedures to contest abusive or inappropriate care and treatment. Particularly in chronic or secure institutions, clients may encounter great practical and legal difficulties in seeking outside review. In Britain, for instance, a special hospital patient secured a criminal verdict against a male nurse for assault only to have the conviction voided by the House of Lords on grounds of staff immunity from prosecution. 551 In Sweden, 11 Salberga Hospital inmates finally petitioned the Justice Ombudsman alleging irregularities in their treatment and retention. 552 In the United States, the courts, filling a void, have questioned the legality and appropriateness of some commitments to custodial mental facilities. 553 Acting because no one else had done so, they ruled in favor of forgotten inmates. Sometimes their judgments countered the complacent assumption that doctors and other professionals always serve the best interests of the inmate who is mentally retarded. 554

More than procedural reform is needed, however. In Norway and elsewhere, laws which permitted involuntary civil commitment of the mental-

We cannot overlook the rights of institutional residents, especially those incapable of eloquent expression and abstract thought. . . . To deny them the right to complain of their treatment because they lack the ability to conceptualize the nature of an oath would be blinding ourselves to reality.

Id.
552. Conditions at Salberga Hospital which gave rise to the complaint are discussed in text accompanying notes 166-77, supra.
554. See Sarzen v. Gaughan, 489 F.2d 1076, 1086 (1st Cir. 1973). The court stated:
The inherently speculative nature of psychiatric predictions, resulting in confinement not for what one had done but for what one will do, demands more than minimal procedures, particularly when such confinement is accomplished outside the traditional criminal process "with its rights to jury trial and other ancient safeguards."

Id. See also Herr, Civil Rights, Uncivil Asylums and the Retarded, 43 U. CIN. L. REV. 679 (1974).
ly retarded have been repealed.\textsuperscript{555} Other jurisdictions are only just beginning to question whether retardation itself should be defined as a condition which renders the subject liable to detention. Subnormality of intelligence per se does not justify detention and should be removed from civil commitment law. Other restrictive provisions, such as plenary guardianship, which single out the mentally retarded for sweeping denials of personal liberty, need revision. This reexamination should consider underlying rationales and factual premises not definitions, criteria, and procedures.

\textbf{B. Recommendations for Action}

1. Model Laws

Beyond human rights declarations, there is a second phase of statutory incorporation and specification which has barely begun. As a stimulant to action, model laws on retardation and related disabilities should be developed and exchanged among nations. That exchange on regional and other levels can reveal defects and outmoded assumptions in current laws, outline more promising approaches, and show the inapplicability of earlier legislative models such as the medical, mental illness, or preventive detention models.\textsuperscript{556}

Model laws can be a first step in meeting the United Nations Economic and Social Council's request that governments take progressive legislative measures to achieve "better integration of disabled persons in the community,"\textsuperscript{557} These measures, the Council recommended, should be aimed at identifying and preventing disability, and assuring "for all categories of disabled persons—physical, sensory or mental—care, education, training, vocational guidance and suitable work as well as social security benefits."

In many nations, law reform is needed to bring national laws into harmony with the United Nations Declaration and the egalitarian model it

\textsuperscript{555} Norwegian law prohibits the compulsory civil commitment of any mentally retarded person over the age of 20. According to the Norwegian official in charge of mental retardation services, this power is not missed. Interview with Dr. Lohne-Knudsen in Oslo (Apr. 18, 1974).

The Commonwealth of Massachusetts has also repealed provisions for civil commitment of the mentally retarded. The Massachusetts statute does not allow the involuntary commitment of a retarded person unless he or she is also mentally ill. Furthermore, mental retardation is not a mental illness within the terms of the law. \textit{Mass. Gen. Laws Ann.} ch. 123, § 1 (West Supp. 1975). \textit{See} Walker, \textit{Mental Health Law Reform in Massachusetts}, 53 B.U.L. Rev. 986, 1015 (1973).

\textsuperscript{556} For a critique of the medical model in current mental health law, see Section IV, A.2, \textit{supra}.

Given agreement on the overall normative framework, this should lead to greater stress on access to generic services and greater adaptation of educational-habilitative services to the needs of mentally retarded persons. In general, law revision can accomplish several aims. It can produce a more suitable terminology and legal standard for service eligibility; recognize multidisciplinary responsibilities in diagnosis, planning, and care; declare habilitation goals broader than simply medical treatment; demarcate agency responsibility for early detection, assessment, guidance, habilitation planning, service finding, and periodic review; specify the objectives and procedures of initial and periodic review; and affirm the client's right to individual dignity and freedom from discrimination. A major task of law reform is to eliminate any special restraints not absolutely required by the disabled person's particular condition and not justified by proper diagnostic procedures and periodic review.

This is not the place to formulate detailed proposals, only to make general observations. Without the needed staff, appropriations, and authority, humane social legislation proves no panacea. Absent these fiscal and human elements, statutory promises of habilitation will go unredeemed. But money is not the measure of the retarded individual's rights. To vote or to marry requires no state investment. To obtain fair procedures in eligibility determinations or in criminal trials demands more diligence than capital. To participate in decisions openly made and to be listened to and heard takes only patience. To have the same access to public facilities as other citizens may only require greater respect by the community for its disabled members. Even the poorest Third World country can avoid adding needless civil disabilities to natural disabilities. Poverty, as

558. Law reform can incorporate new scientific and professional knowledge. It can also be the occasion for introducing greater conceptual clarity in formulating mental disability policies. Dr. Alan A. Stone, Professor of Law and Psychiatry, Harvard University, has found that clarity particularly lacking in the mental retardation field.

Nowhere in the interaction between law and mental health is there more ambiguity, more confusion, and more failure to articulate and achieve goals than in the area of mental retardation.


560. The author is grateful to Kate Paul, who, working directly with emotionally disturbed children in London, reminded him of those central elements.
well as experience, can keep one from constructing expensive and destructive ways to segregate retarded persons from their neighbors.

2. The Uses of Advocacy

Rights are hollow if one does not understand them or have representatives who do. This raises a basic question: who, if anyone, has the duty to advocate for the rights of the inarticulate and the forgotten? Due to the complexity of rights and the vulnerability of their beneficiaries, the mentally retarded present a particularly poignant case.561

In industrialized societies, rights for the retarded are derived from many sources. These rights are often poorly codified, enshrouded in technical language, and ambiguous. If poorly understood by professionals and service providers, to clients and families of clients they pose even greater mysteries. Small societies, undergirded by face-to-face ties and shared internal norms, do without this legal subculture. In societies neither small nor utopian, however, rules count for more, mores for less. The sovereign, often a prime violator of human rights, must be pressed to make human rights more effective.

Advocacy for the retarded is a means to that end. Declared rights will be dead letters as long as the public and the legal profession remain ignorant of them. Moreover, by default and by design, people labelled “mentally retarded” needlessly lose rights that the rest of us would fight to keep. Advocacy, whether by laymen or lawyers, concerns securing for the disabled the same basic rights and benefits as other citizens enjoy. Since filing this recommendation, two countries, Sweden and the United States, have introduced new advocacy services for the mentally disabled.

While few require guardians, many disabled individuals will require aid in dealing with welfare bureaucracies, residential facilities, and the complications of a more integrated life. In the past, the residential superintendent or social services director was expected to safeguard his clients' collective interests. But with responsibilities to many clients, to staff, to superiors, and to the general public, the superintendent or director became more an arbitrator of, rather than spokesman for the client's individual interest.

To deal with these conflicts of interest, the Swedish Law on Guardianship and Trusteeship provides the more severely retarded or mentally ill person with the graded assistance of a paid and independent spokesman.562 Since


562. See Section III, C.1, supra.
1976, the courts have been empowered to appoint a trustee for a mentally disabled person whose need of ongoing assistance requires some special measure short of plenary guardianship. Given a legal status and compensation, the trustee (or mentor as he might better be called) is to give priority to his client's personal interest over any other class of interest. Each American state is required under the Developmentally Disabled Assistance and Bill of Rights Act to establish an independent agency to pursue the individual rights of disabled persons. By October 1977, each state is to have in effect a "system to protect and advocate the rights of persons" with mental retardation, cerebral palsy, epilepsy, and other developmental disabilities. While guidelines do not fix any single method of implementing this statutory requirement, the Act, according to the Department of Health, Education and Welfare, places rigid restrictions on the implementing agency "so that there may be no conflict of interest." Unlike the Swedish law, the federal act emphasizes a comprehensive advocacy approach "to uphold and safeguard the rights of developmentally disabled people." A primary task is "representing individuals or organizations . . . on matters relevant to the protection of the legal and human rights of developmentally disabled persons." These are but two examples of domestic laws that fund advocates who can turn disability declarations into action.

3. The Case for Compliance Machinery

a. Whose Duty to Care?

Human rights are everyone's responsibility. Everyone's responsibility, too often, becomes no one's responsibility. Little is known about the political institutions that might rescue human rights declarations from ridicule and obscurity. To save the disability declarations from just such oblivion, the following recommendations link the United Nations Declarations of 1971 and 1975 to parallel domestic law reforms. The relevant question at both international and national levels is who will have a duty to care after rights are declared.

565. Id. at 11.
b. Whose Duty to Monitor?

Preserving human rights depends on arousing concerned public opinion and on tapping a government's capacity for shame and regeneration. If no one from the United Nations, from the international nongovernmental organizations, or from domestic bodies and organizations will raise questions and investigate complaints, little can happen. In the field of mental disability, those questions can usually be asked without fear of retaliation or oppression.\(^{567}\)

Given the unanimous General Assembly approval of both the Declaration on Retarded Persons and the Declaration on Disabled Persons, no sovereign state can disagree on the broad human rights principles to be applied. Unfortunately, no nation has yet demanded further action to make those declarations more effective internationally.\(^{568}\) In very few nations have public agencies or other bodies begun to monitor discriminatory conduct against either domestic or international norms.

Moreover, there are a wide variety of legal techniques within domestic law which can be more frequently used to combat discrimination or ill treatment of the disabled. For example, legislation can provide compensatory treatment or redistribute benefits. Administrative regulations can set standards of decent care and training for mentally retarded clients and workers. Contracts, by or on behalf of retarded persons, can impose ascertainable duties upon employers or service providers. Civil judicial decrees for retarded plaintiffs can enjoin some harm, compel some protection, or compensate some wrongful act or omission. Penal prohibitions can deter the cruel and willful maltreatment of a vulnerable minority.

National handbooks describing legal and political methods for applying rights could help the mentally retarded and their families. Scholarly research, comparing the effectiveness of these various techniques, could also be of long-term benefit. In implementing and interpreting the 1971 United Nations Declaration, there are many questions deserving of further study. For example, how can laws and legal institutions incorporate new knowledge of retardation and its amelioration? If the retarded person has a right to protection from exploitation, abuse, and degrading treatment, who has the duty to monitor, investigate, and rectify apparent breaches of that right? If

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567. This, as the incarceration of Soviet dissidents in psychiatric institutions reveals, is not always the case. See, e.g., Letter from A.S. Yesenin-Volpin to the Editor, N.Y. Times, Dec. 5, 1976, § 1, at 12, col. 6, regarding Vladimir Bukovsky's seven-year prison sentence for sending information to the West about Soviet psychiatric incarcerations.

he or she has a right to home and community life as close as possible to normal, to what forum does appeal lie when unjustifiable discrimination destroys that expectation? What standard defines “normal?”

c. The Principle of Economy of Redress

An advocate, however energetic and well-motivated, cannot apply to legislatures and courts to redress every denial of a client's rights. Judicial proceedings may be warranted if complaints involve issues of great public importance or serious violation of individual rights. Less formal procedures may be desired if more mundane matters are at stake. Similarly, lobbying for new or amended statutes consumes time and energy. This requires careful study, political mobilization, and the scarce resource of legislative time. It too is not to be lightly undertaken.

d. Alternative Forums of Redress

New forums and channels for grievances, as earlier explained, are a legacy of the disability rights movement. Some operate at the level of the individual: the citizen advocate, legal advocate, or social worker. Their task is to intercede with authorities and the public to advance the client's rights. Others are organized around the institution or the community facility, for example Denmark's parent representative, Alabama's Human Rights Committees, or Willowbrook's Review Panel. On a regional basis, boards and committees, composed primarily of consumers and their representatives, can act as human rights monitors. At national levels,

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569. Denials of vital social services may certainly raise judicial issues. The right to such services in a welfare state, as a leading British jurist observed, cannot be left to the "uncurbed discretion of the executive." Diplock, Administrative Law: Judicial Review Reviewed, 33 CAMBRIDGE L. REV. 233, 236 (1974). See also L. SCARMAN, ENGLISH LAW—THE NEW DIMENSION, supra note 267, & text accompanying notes 299-306, supra.

570. Discussed at note 506, supra.


572. The Review Panel was created by consent agreement between representatives of Willowbrook's institutional residents and New York State. Aided by a professional field staff, the Panel reports to the federal district court on compliance with the class action consent decree on community alternatives and protection from harm. New York State Ass'n for Retarded Children v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975).

573. First by agreement and then by statute, Florida established statewide and regional Human Rights Advocacy Committees. These committees are to discover, investi-
specialized administrative bodies can perform monitoring and reporting functions: for example, the Mental Welfare Commission for Scotland,\(^{574}\) Britain's Health Service Commissioner,\(^{575}\) or Sweden's National Board of Health and Welfare and its Mental Retardation Bureau.\(^{576}\)

There are also familiar channels by which the mentally handicapped and their friends can bring a complaint or air a grievance. As this article has shown, the mentally handicapped do sometimes invoke the aid of the courts, the national ombudsman, or the parliamentarian. Through publicity, the victimized retarded person can also gain the public's attention and the support of politicians, journalists, and private pressure groups.

Resorting to court action is still a process which can be complicated, uncertain, and costly. While a judicial decision may result in a final, public, and conclusive determination, obtaining that result requires patience and skilled assistance. Without that assistance, aggrieved persons may not raise important human rights questions deserving of thorough and impartial review.

Administrative remedies are not immune from similar limitations. They too depend on private complainants to reach an official with the jurisdiction and disposition to resolve their problems. Most national ombudsmen, for example, only rarely deal with complaints relating to disability. Moreover, an ombudsman is not a substitute for due process in institutional admissions or for periodic review of “away from home” placements. Furthermore,

\(^{574}\) The Mental Welfare Commission for Scotland is discussed at Section IV, D.3(b), supra.

\(^{575}\) The Health Service Commissioners are discussed at Section IV, D.3(a), supra.

\(^{576}\) This specialist branch of the National Board of Health and Welfare has direct responsibilities for inspections and for investigating complaints of service recipients. For discussion of this central state agency, see Section III, B.3, supra.
ombudsmen generally lack enforcement powers, counting more on their bark than their bite.

Administrative tribunals may have authoritative powers and greater expertise. Creatures of limited statutory delegation, they resolve disputes of fact or law in narrow specialized fields, such as compulsory detention, or welfare benefits, or special education placement. The English Mental Health Review Tribunal, for example, has no duty to mobilize others or remedy wrongs not relating to discharge.\footnote{577}

Inspectorates may identify breaches of regulations and minimum care standards. Lodging that mandate in agencies identifying with the government or service providers can inhibit vigorous enforcement. Lack of adequate manpower or political support can also lead to tokenism. Inspection can become little more than a sporadic visiting scheme, with knowledge of results and standards withheld from the public.\footnote{578}

Public inquiries sometimes examine the maltreatment of retarded individuals. By their very nature, these are after-the-fact attempts to assess what went wrong and why. In England for example, these inquiries, with disturbing regularity, uncover gross indignities to institutional residents. The resident, if still alive, and his family have no right to legal aid and the inquiries are ill-equipped to search out the underlying causes or extent of resident abuse.\footnote{579} These “one-shot” investigations are not substitutes for a more expert and continuing overview.

e. A Focus for Human Rights: Commissions on Disability Rights

A special commission can mobilize and coordinate ongoing activities concerning rights for retarded and other disabled persons. In 1975, at the Sixth World Congress of the International League of Societies for the Mentally Handicapped,\footnote{580} the author proposed that various nations form “Commissions on the Rights of the Disabled” (hereinafter “Commission”) or

\footnote{577}{For discussion of the English Mental Health Tribunals, see Section IV, D.3(c), \textit{supra}.}

\footnote{578}{While Britain’s Department of Health and Social Services has some minimum standards for mental subnormality hospitals, these are said to be known only to the most senior National Health Service officials. Interview with William Duff (trade union officer, Confederation of Hospital Staff Employees) in London (Oct. 31, 1975). Furthermore, institutions for the mentally handicapped child are outside the coverage of normal child and social welfare visits and standards. See, \textit{e.g.}, DHSS, \textbf{MENTALLY HANDICAPPED CHILDREN IN RESIDENTIAL CARE} (H.M.S.O. 1974).}

\footnote{579}{For discussion of those inquiries, see Section IV, A and D at pp. 245-47, 256-66 \textit{supra}.}

\footnote{580}{The International League (ILSMH) and its activities are described at note 46 and in Section II, \textit{supra}.}
This recommendation further outlines the C.R.D. proposal.581

Some caveats are in order. It is not now possible or desirable to supplant all monitoring mechanisms with any single public entity. Nor are Commissions replacements for the previously described advocacy on behalf of disabled individuals. They do, however, have complementary roles in making rights effective. A public entity can be uniquely equipped to serve as a focus and educative force for upholding the rights of the disabled. Commission functions can be tailored to national needs and the scope of powers assigned to it by national leaders. For example, by executive order or by legislative act, a Commission can be charged to review laws, policies, practices, and implementation respecting the rights of mentally retarded persons or, preferably, some broader category of disabled persons. This review could take place against the background of applicable international, constitutional, and other legal principles, as well as evolving professional and societal standards.

Depending on national resources and needs, the C.R.D. could perform or delegate four types of functions, in whole or in part. These could include:

1. monitoring and study of laws and policies of general application, and proposals for their reform;
2. public education and information;
3. settlement or referral of individual complaints; and
4. supervision and training of local human rights committees and client representatives.

The Commission can have centralized and decentralized features. Varying with the area and responsibilities it covers, it can be replicated at local, regional, and even multinational levels. For example, a C.R.D. could help organize human rights committees and client representatives to operate on a regional or facility basis. These local committees and representatives might help to monitor and investigate complaints of unjustified deprivations of liberty, failures of service, or discrimination in access to services or accomo-

581. Herr, Rights Into Action, supra note 4, at 135-38. That proposal was presented before the ILSMH Executive Committee and the Assembly of Delegates. For a favorable review of the proposal, see Shearer, Mental Handicap, 33 NEW S.C'Y 699 (Sept. 25, 1975).
582. A “C.R.D.” could also be developed at the state or other levels of government. While some commissions are temporary and are formed for study purposes, see, e.g., Commission for Control of Epilepsy and its Consequences, 42 U.S.C.A. § 289 (Supp. 1976); Royal Commission on Mental Illness and Mental Deficiency, supra note 246; NEW JERSEY STATE COMMISSION ON MENTAL HEALTH, TOWARD BETTER MENTAL HEALTH IN NEW JERSEY (1961); the C.R.D. proposed here would be a standing commission serving broader monitoring functions.
With a mix of consumer, professional, and legal members, these independent committees could, through disciplined fact-finding, review of alternative dispositions and recommendations, do much to conciliate and informally settle the majority of complaints. Complainants would have direct access to these committees. Complaints or suggestions could originate from any source, including disabled persons, their relatives, friends, advocates, and professionals who treat them.

The Commission could review matters not remedied locally or matters involving wider geographical or socio-legal issues. Still emphasizing conciliation and negotiation, the Commission could have reserve powers to conduct inquiries and to bring civil proceedings to obtain a declaration of law or to restrain a course of unlawful conduct. A C.R.D. could perform other tasks safeguarding human rights of the disabled. It could prepare reports for the public, the legislature or other authorities; comment on proposed regulations or laws of special impact; recruit, train, and assist local Human Rights Committees; and coordinate promotional, research, training, and advisory activities on rights-related matters. At present, few jurisdictions have agencies to consider systematically the impact of proposed laws, regulations, policies, technologies, and professional practices on the intellectually deficient citizen. Too often neutral review comes after, rather than before harm is inflicted. Mentally retarded minors are first sterilized, then the absence of any guidelines is decried. Institutional residents are subjected to nontherapeutic experiments, then the necessity of the experiment is questioned. Disabled infants are denied life-saving treatment, then public discussion is provoked. Time and again, the review and public debate which does occur is more fortuitous than deliberate.

A Commission cannot do everything, but it can organize what needs to be done. In specific countries, the functions a C.R.D. performs will take into account considerations of cost, competing agencies, professional autonomy, and administrative efficiency. But the interests ultimately involved—human freedom and protection from suffering and pain—merit expense and great caution. Moreover, a C.R.D. can be an indirect fiscal check by determining whether already substantial public expenditures for the disabled do in

583. Disabled persons may depend on publicly supported services for their very survival and well-being. No matter how deficient those services might be, some are unable to find alternatives.

As "deinstitutionalization" gains momentum, mentally disabled people will come into contact with a wider variety of public agencies, each with its distinctive appeal and grievance procedures. In an ideal society that would be enough. But for now a Commission on the Rights of the Disabled would have much to do in bringing about real and beneficial social integration.
fact promote the well-being and rights of the intended beneficiaries. The cost of a Commission is minimal when set against those expenses and the human rights at stake.

A Commission on the Rights of the Disabled can have the prestige, independence, and expertise to assume both educative and grievance-settling roles. It can be a powerful reminder that the rights of the disabled are valued enough for society to share in the burden of their enforcement. Its establishment can be more than a symbolic gesture. As an independent watchdog, the Commission should be able to undertake or set into motion inquiries into suspected abuse or discrimination. That power, as this article has demonstrated, is not unprecedented.

There is, as the distinguished English constitutional lawyer S.A. de Smith explained, “something peculiarly exasperating about a broad affirmation of fundamental human rights unaccompanied by any machinery for giving them effective legal protection.” Aware of precisely that, many societies are finding ways—through advocacy and independent forums—to turn human rights into action.