MENTAL HEALTH

THE RIGHT TO TREATMENT FOR MENTALLY RETARDED CITIZENS: AN EVOLVING LEGAL AND SCIENTIFIC INTERFACE

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INTRODUCTION

The first half of the decade of the 1970’s has seen an assault upon a citadel of 19th Century thought in America: state institutions for the mentally retarded.¹

¹ Over the years, there have been many definitions of mental retardation which attempted to differentiate between the intellectually subaverage and those persons having “normal” intelligence. Unfortunately, these definitions have generally been couched in extremely negative terms such as “idiot,” “imbecile,” “moron,” “low-grade,” “high-grade,” “custodial,” etc. Many of these terms are still used to describe the retarded; they not only set the mentally retarded apart from other members of society, but convey a picture of subhuman status, prolonged dependence, and a seriously restricted ability to develop or learn. See generally Doll, The Essentials of an Inclusive Concept of Mental Deficiency, 46 AM. J. OF MENT. DEFIC. 214 (1941); C. BENDA, DEVELOPMENT DISORDERS OF MENTATION AND CEREBRAL PALSES (1952); R. MASLAND, S. SARASON, AND T. GLADWIN, MENTAL SUBNORMALITY: BIOLOGICAL, PSYCHOLOGICAL AND CULTURAL FACTORS (1958). Such images have all been employed as justifications for isolation from the community, custodial care and over-protection. Accordingly, the definition of mental retardation is a very important consideration.

A widely used definition of mental retardation which is generally accepted in the United States was adopted by the American Association on Mental Deficiency (AAMD) in 1973. See H. GROSSMAN, MANUAL OF TERMI-
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A rapidly developing scientific understanding, both of the nature of mental retardation and the vast developmental potential of mentally retarded citizens, has challenged the raison d'etre for

NOLOGY AND CLASSIFICATION IN MENTAL RETARDATION (1973). This definition states that: "Mental retardation refers to significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested in the developmental period." Id. at 5. The terms used in this definition may be explained as follows:

SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING: Falling below 97% of the population on standardized tests of global intelligence. Tests of this type are used to sample a wide range of knowledge and skills in order to compare a person's test performance to a standard established for his age level. A person exhibiting knowledge and skills similar to the standard for his age group is considered average. Below and above average performance, therefore, means that a person's test performance is comparable to persons either younger or older than himself. See generally P. WECHSLER, WECHSLER ADULT INTELLIGENCE SCALE (1955) and L. TERMAN, M. MERRILL, STANFORD-BINET INTELLIGENCE SCALE (1972).

DEVELOPMENTAL PERIOD: From conception to about 16 years of age.

ADAPTIVE BEHAVIOR: The ability to adapt to and control one's environment, usually defined in terms of maturation, learning and social skills. See generally E. DOLL, THE VINELAND SOCIAL MATURITY SCALE (1941) and E. BALTHAZAR, BALTHAZAR SCALES OF ADAPTIVE BEHAVIOR FOR THE PROFUNDLY AND SEVERELY MENTALLY RETARDED (1958).

It should be noted that the AAMD definition is based upon a dual concept of mental retardation: it is defined in terms of reduced intellectual functioning which, in turn, is associated with deficits in adaptive abilities. Even though this definition is more general than earlier statements, it does adequately stress the learning, growth and developmental potentials that exist for mentally retarded persons.

Persons attaining measured intelligence scores significantly below 100 (100 is considered to be average) are usually classified according to levels of mental retardation as follows:

<table>
<thead>
<tr>
<th>Level of Retardation</th>
<th>Standardized Intelligence Test</th>
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<tbody>
<tr>
<td>Mild</td>
<td><strong>52-67</strong></td>
</tr>
<tr>
<td>Moderate</td>
<td><strong>36-51</strong></td>
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<tr>
<td>Severe</td>
<td><strong>20-35</strong></td>
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<tr>
<td>Profound</td>
<td>Below <strong>20</strong></td>
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Basic to the use of intelligence tests is the assumption that the person taking the test has had similar opportunities to learn and shares a common language and culture with those persons on whom the test was standardized (e.g. culturally unfair tests in English rather than the testee's native language). Clearly, a number of factors other than intelligence can significantly depress test scores (e.g. sensory impairments, motivation to perform well in a testing situation, anxiety associated with test taking, and mental illness). See generally J. MERCER, LABELLING THE MENTALLY RETARDED (1973).

The second criterion used in the diagnosis of mental retardation is adaptive behavior. In the AAMD Manual on Terminology and Classification, adaptive behavior is defined as referring primarily to the effectiveness with which the individual copes with the natural and social demands of his environment. It has two major facets: (1) the degree to which the individual is able to function and maintain himself independently, and (2)
massive residential institutions. The conceptual elements of this current understanding, casting off stereotypes regarding the mentally retarded, emphasize the habilitation of mentally retarded cit-

The degree to which he meets satisfactorily the culturally-imposed demands of personal and social responsibility. H. Grossman, Manual of Terminology and Classification in Mental Retardation 11 (1973).

As in the case of measured intelligence, adaptive behavior is evaluated by comparing an individual with members of his own age group. Thus adaptive behavior is always evaluated in terms of the degree to which the individual meets the standards of personal independence and social responsibility expected of his chronological age group. For example, maturation would be emphasized during early childhood years in which such skills as sitting, standing, walking, self-feeding, toileting and speech are ordinarily developed. Academic performance would be stressed during school age years, while vocational and social effectiveness would be appropriate topics for adults.

A positive correlation should exist between measured intelligence and adaptive behavior. That is, an individual who ranks relatively high in one dimension would be expected to rank high in other areas as well. Marked discrepancies between measured intelligence and adaptive behavior (e.g., an intelligence quotient within normal limits coupled with a subaverage adaptive behavioral level, and vice versa) would cast serious doubt upon the diagnosis of mental retardation.

In summary, the diagnosis of mental retardation is made on the basis of two dimensions: (1) measured intelligence, and (2) adaptive behavior. No person should be classified as mentally retarded until he or she has been evaluated by a team of qualified professionals—including representatives from the medical, social, educational, and psychological disciplines. Moreover, the assessment should not be considered complete unless parents or relatives have been involved in the evaluation process as significant observers, and the person's adaptive behavior has been assessed in relation to his community and family situation, and taking into account the cultural norms of their environment.

2. The burgeoning current national interest in the mentally retarded can be traced to the establishment of the National Association for Retarded Citizens (NARC) in 1950 as a citizen advocacy group to spur change in the field, and the creation of President John F. Kennedy's Panel on Mental Retardation and the subsequent federal mandate in 1963. Message from President Kennedy on Mental Illness and Mental Retardation, Feb. 5, 1963, in 109 Cong. Rec. 1744 (1963). For example, NARC, a 250,000 member organization of parents of the retarded, professionals in mental retardation, and concerned citizens, has been a pioneer in initiating educational, vocational, and residential models across our country and then prompting local, state and federal levels of government to accept these services as part of their generic service aids to all retarded citizens. NARC has recently turned its attention to actively litigating for sweeping changes while steadfastly monitoring what they initiated. See 1975 Nat'1 Ass'n for Retarded Citizens Ann. Rep. Similarly, members of President Kennedy's Panel on Mental Retardation, in their 1962 report, outlined 99 recommendations on what had to be done on a national scale and then helped to develop the rationales for the establishment of: (a) alternative models of care, (b) research guidelines, and (c) new training programs for enlarging the professional workers on behalf of the mentally retarded. See President's Panel on Mental Retardation, Report to the President: A Proposed Program for National Action to Combat Mental Retardation (1962).

Mental retardation has been championed by our last four Presidents,
zens in integrative community programs and services. The aftershocks of this understanding are now reverberating through the legal superstructure of the institution, as federal courts, in growing numbers, recognize the constitutional rights of mentally retarded citizens. This interface of the developing scientific understanding and legal activism merits an examination. To understand one and not the other is to understand neither.

HISTORICAL PERSPECTIVES

Prior to the modern age, the early history of mental retardation, like mental illness, was dominated by primitive thinking that tended to attribute the problems to various supernatural causes. At the dawn of the 19th Century, a French psychiatrist, Jean-Marc Gaspard Itard, reported on his five year project of "educating the mind" of Victor, a mentally retarded adolescent, known as the "Wild Boy of Aveyron." Itard's report sparked the beginnings of

Recently stated (1972) Presidential goals include a strong focus on the prevention of mental retardation and a de-institutionalization focus wherein a significant proportion of the over 180,000 retarded individuals in public institutions will be able to return to useful lives in their communities. The recently completed President's Committee on Mental Retardation Report clearly enumerates what must be accomplished during the remaining years of this century to bring equal rights to the retarded. This Report is a clarion call, replete with specific recommendations for treatment and habilitation. See President's Committee on Mental Retardation, Mental Retardation: Century of Decision (1976). Viewed in these recent historical perspectives, the treatment and habilitation of the mentally retarded stand today at a most exciting point in the evolution of professional and citizen involvement.


5. Except for the works of Hippocrates and a few of his contemporaries, mental retardation or any identifiable description of it does not appear in the medical writings of antiquity. The physicians of the first eighteen centuries of the Christian era had precious little interest in mental retardation or mental illness and their manifestations. See generally L. Kanner, A History of the Care and Study of the Mentally Retarded (1964).

6. In 1801, Itard reported on his efforts to educate Victor, a "wild
widespread scientific and professional concern with "idiocy" (mental retardation). This work clearly illustrated what a creative, humanistic, and highly structured approach to the mentally retarded could accomplish. Itard's approach to the mentally retarded would become the professional underpinnings of the early state supported schools for the retarded in America in the mid-1800's. These early institutions emphasized the development of skills for a more independent life upon the part of the mentally retarded.

Itard devised and vigorously pursued a system of sensory input and rigorous habit training. Victor, who had been viewed as severely retarded when Itard commenced treatment, responded very favorably: he commenced to walk in an upright position, fed and dressed and toileted himself, developed language, etc. Itard's treatment program for Victor embodied the following principles and objectives: 1) to endear him to social life by making it more congenial than the one he had recently been leading; 2) to awaken his nervous sensibility by the most energetic stimulants and at other times by quickening the affections of the soul; 3) to extend the sphere of his ideas by creating new wants and multiplying his associations with surrounding beings; 4) to lead him to the use of speech by determining the exercise of imitation, under the spur of necessity; and 5) to exercise, during a certain time, the simple operations of his mind upon his physical wants, and therefrom derive the application of the same to objects of instruction. See generally H. Lane, The Wild Boy of Aveyron (1976); J. Itard, The Wild Boy of Aveyron (1832).

Itard's dramatic treatment results with a retarded youth inspired another Parisian psychiatrist, Eduordo Séguin, to work with the retarded. Séguin noted that the education and training of the retarded: "Consists in the adaptation of the principles of physiology through physiological means and instruments, to the development of the dynamic perceptive, reflective and spontaneous functions of youth." E. Séguin, The Moral Treatment, Hygiene and Education of Idiots and Other Backward Children 89 (1848). It is upon Séguin's principles, extended by successive behavioral scientists and educationalists that most of our present methods were and are based.

It is interesting to note that the pioneer work of Itard and Séguin was focused on the severely retarded. This historical fact seriously questions the hopelessness toward the severely retarded that persists to this day. The treatment potentials were always present, and successful techniques were elaborated early. Thus it appears that it was the eugenic alarm that turned professionals away from what could and should be done on behalf of the severely retarded. See generally Ball, Training Generalized Imitation: Variations on an Historical Theme, 75 Am. J. Ment. Defic. 135 (1970). Ball points out that the treatment procedures now being rediscovered in mental retardation, were used by Itard and Séguin 100 years ago and that their dormant status does not detract from raising the question of why these treatment techniques are not more widely applied in modern service agencies for the retarded. Id.


8. The Nebraska response during this period was representative of
However, in the last decade of the 19th Century, another fateful trend was developing. The Parisian School of Psychiatry and Neurology turned its attention to causative factors that produced the symptom of mental retardation. It soon viewed all instances of mental retardation as stemming from defects in brain development. This defect position was also utilized to “explain” some occasional behavioral manifestations associated with mental retardation which were being recognized more frequently. Most retarded individuals with such problems were identified in adolescence and came to the “idiot asylums” as social misfits, neglected children, or both. Evident limitations in the “learning of let-

...
ters," and the frequent association with social failure prompted English psychiatrists to term these individuals initially as "moral imbeciles."\[13\]

Born on the crest of a dawning social conscience, the 19th Century initially witnessed the recognition of mental retardation as a condition in which the intellectual faculties have never developed sufficiently; the introduction and vigorous pursuit of a rational plan for "educating the minds of idiots." Much of which is accounted today as "new developments" in the care, education, and teaching of the retarded had been anticipated with sophisticated skill by many 19th Century psychiatrists.\[14\] As the 20th Century approached, the ascendency of the defect position in professional thinking became associated with waning hopes for the education of the retarded. The previous focus of sheltering the retarded from society was drastically altered to one of protecting society from the retarded. Concomitantly, the residue of benevolence toward the retarded faded away.\[15\]

At the beginning of the 20th Century, in a timespan of only about twenty years (1910-1930), three important trends coalesced into a tragic interlude which left a lasting imprint on professional involvement and treatment enthusiasm in mental retardation. The following three crucial developments, operating in a symbiotic relationship, administered the coup-de-grace to the dynamic movement which had been initiated by Itard: 1) introduction of the Binet Intelligence Test to America in 1908;\[16\] 2) publication of

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13. See generally W. Griesinger, Mental Pathology and Therapeutics (2nd ed. 1860).


16. The Binet Test was the first widely utilized standardized test for assessing human intelligence—especially by comparing different levels of expected ability at the differing age levels. It promised a rapid assessment of both a person's current level of abilities and suggested expectations for future social and vocational attainment. Accordingly, it was viewed as a quick method for assessing an individual's adjustment potentials and rapidly replaced the more lengthy and thorough clinical assessments of the psychiatrist. Almost overnight, the Binet Test and its subsequent modifica-
Goddard's monograph on the Kallikak Family in 1912; introduction of psychoanalysis to American Psychiatry by Brill, also in 1912.

Tions gained acceptance as a crucial diagnostic technique for mental retardation. Indeed, it soon came to be utilized as the one and only guide for educational programs and even for the prognosis of social effectiveness. The discovery of vast numbers of “morons in our midst” through the use of mental tests soon became a matter of widespread concern, especially because so many of the mildly retarded appeared to be “social misfits.” The fact that it was mostly the “social misfits” that came under scrutiny was overlooked, and the conclusion was drawn that all retarded individuals were social problems, or potentially so.

17. H. Goddard, The Kallikak Family (1912). Goddard’s book was one of a number of pseudo-scientific reports which indiscriminately equated genetic inheritance with social irresponsibility. See generally W. Fernald, History of the Treatment of the Feebleminded (1912); M. Barr, Mental Defectives (1904). These books contributed to the growing consensus which, in time, reached four distinct conclusions: 1) there were more retarded persons in our society than people realized; 2) the mentally retarded accounted for virtually all of the current social ills; 3) heredity was the major cause of mental retardation; and 4) since the “decadent” retarded appeared to reproduce faster than non-retarded citizens, society would soon be destroyed unless drastic measures were taken. H.W. Potter, a psychiatrist who had worked with the mentally retarded for over 60 years, reflected in 1970 on this “eugenic alarm” as follows:

[T]he mentally retarded were viewed as a genetic menace and a political and social threat to the American way of life. The retarded were regarded as socially irretrievable because a grandfather had bitten the family tree and poisoned it or because some kind of “brain fever” had left its victims with an irreparable “hole in the head.” It was believed that the retardation itself carried with it a high probability of social irresponsibility, popularly peddled as “the menace of the feebleminded.”

With this as the popular image of the mentally retarded, a great hue and cry went forth which bade “welfare ladies” and “overseers of the poor” to “beat the bushes” in order to identify the retarded and commit them, one and all, to institutions. No one who has not lived through those days (as has this author) can appreciate the nationwide dedication to this policy of identification and institutionalization. It was a patriotic duty! Was not the preservation of the American democracy worth the effort? This is not an exaggeration!

Many a retardate was committed to an institution with the conviction that he or she should remain there for the rest of his or her natural life. It was fiscal policy that those committed should earn their board and lodging by “the sweat of their brow.” They did so in those years, and they do today in some places! Those whose mental and physical infirmities made them unemployable in the institutional community lived out their lives in a bed or a wheelchair or on a dayroom bench. They did so in those days, and they do, in some places, today!


18. While the concepts of the quick I.Q. test and eugenic alarm were jelling, the largest group of professionals involved in mental retardation—psychiatrists—began to rapidly assimilate the dynamic concepts of psychoanalysis into American Psychiatry. Psychotherapy efforts with the psycho-
The Binet test quickly became viewed as a rapid assessment technique for general intelligence and the case study approach of the psychiatrist became expendable. Goddard's pseudoscientific monograph attributed mental retardation to a fixed genetic disorder which literally "ran in the family," and was not amenable to treatment. Psychoanalysis captivated and riveted the attention of American Psychiatry to theoretical and clinical challenges ranging from early personality development to dream analysis—leaving the "prosaic" challenges of mental retardation to others. In brief, these three dimensions of the tragic interlude induced the interests of the major professional group in mental retardation at that time—psychiatrists—away from its past commitment to the thorough assessments approach with resultant programs of humane service. Instead, the ideology and practices of penology became the focal point for controlling retarded individuals whom Goddard had described as degenerative and dangerous to our society.

The repercussions of the tragic interlude stimulated major financial commitments, on a national scale, to the construction of ever larger institutions in which to incarcerate the "dangerous" retardate. From the early 1900's until 1960, the institutional neuroses served to entice psychiatrists away from allegedly prosaic and purposeless activities in mental retardation. After all, the challenge of working with "brain impaired social misfits" was not a rosy one, and Itard's efforts with Victor were forgotten. It is interesting to note the historical reference wherein virtually all of the social and behavioral difficulties of the retarded were attributed to genetically induced mechanisms of brain impairment. See generally T. Szasz, The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (1961). Szasz argues, for the opposite reason, that the term "mental illness" has undergone the same transformation, and thus it is a misnomer. Psychiatric problems, he feels, represent deviations from social, ethical, and political norms and, thus, are not amenable to traditional medical approaches or treatments which are based on physiological or anatomical deviations from a norm. In similar fashion it has been noted that 85% of the mentally retarded are in the mild range, and the cause of their retardation, past and present is psychosocial in kind and thus primarily treatable by educational and other behaviorally based treatment and management approaches. See generally H. Potter, Foreward, Psychiatric Approaches to Mental Retardation (F. Menolascino ed. 1970); American Medical Association, Mental Retardation: A Handbook for the Primary Physician (1964) and President's Committee on Mental Retardation, MR-2000 (1976).


20. See generally A. Deutsch, The Mentally Ill in America: A History of Their Care and Treatment from Colonial Time (2d ed. 1949); G. Dybwad, Challenges in Mental Retardation (1964); G. Dybwad, Roadblocks to Renewal of Residential Care, in Psychiatric Approaches to Mental Retardation 552 (F. Menolascino ed. 1970); B. Blatt, Exodus from
leitmotif became "protect society from the deviant." In rapid succession, restrictive marriage and sterilization laws, and lifelong segregation ("ware-housing") of retarded individuals in inexpensive institutions fostered a posture of "dehumanization." The


21. The Nebraska Legislature followed the professional view of this period by dehumanizing its institutional purpose through emphasis placed upon segregation and classification of the feebleminded (mentally retarded). Law of Apr. 25, 1921, ch. 241, § 1, [1921] Laws of Neb. 843, as amended, Neb. Rev. Stat. § 83-218 (Reissue 1971), provided: The objects of the institution shall be to provide custodial care . . . to segregate them from society, to study to improve their condition, to classify them . . . ."

A further example of how the "eugenic alarm" spawned legislation designed to protect society from the "menace" of the mentally retarded citizen was the 1935 Nebraska statute which created the State Commission for the Control of the Feebleminded. Law of May 27, 1935, ch. 143, § 1, [1935] Laws of Neb. 533 (repealed L.B. 178, § 1, [1951] Laws of Neb. 1096).

The purpose of the statute was to confine or sterilize every feebleminded person within the state. To achieve this end the commission was granted extensive power over both those classified as feebleminded and those individuals suspected of being feebleminded. To ascertain which persons were under their domain the commission was to maintain a continuous census of the feebleminded. In addition to obligating doctors, nurses, hospitals, institutions, welfare boards, health officers and other public officers to report to the commission, the statute provided for access when necessary to examine children and their school records.

Decentralization was provided in the form of a sub-commission comprising the commissioners of insanity from each county. The commission submitted to the sub-commission a list of all feebleminded citizens in that county. Within thirty days the sub-commission investigated and examined each person on the list to determine whether or not he was feebleminded. A complete list, revised and supplemented periodically, containing the names of all those found to be feebleminded and residing within the state was distributed to the Department of Health, to each county that issued marriage licenses and other agencies empowered to issue marriage licenses. No mentally retarded citizen whose name appeared on the list was eligible for a marriage license until the commission was satisfied that he or she had been sterilized or was otherwise incapable of procreation. Id.


The Nebraska Supreme Court in 1931, while upholding the constitutionality of this statute and exemplifying the then current thinking, stated:

"The legislative act before us is in the interest of the public welfare in that its prime object is to prevent the procreation of mentally and physically abnormal human beings. We think it is within the police power of the state to provide for the sterilization of feebleminded persons as a condition prerequisite to release from a state institution.


24. Dehumanization is manifest in long-term patients by their shuf-
prevailing professional-societal expectations left little room for the humane and therapeutic models that had typified the earlier professional roles in mental retardation and the role of psychiatry became that of Charon.\textsuperscript{25}

A close review of this period (1900-1960) clearly reveals that professionals literally led the field into a wilderness. The arguments brought forth to support mass sterilization, enforced labor, and the inexpensive warehousing by the leading “defectologists” of that era\textsuperscript{26} could be viewed as merely unfortunate if the results of their labors were not so disastrous.\textsuperscript{27} This era was typified not only by a loss of rationales for prevailing institutional practices, but a continuation of momentum for the practices which evolved from these outdated professional rationales.\textsuperscript{28}

...fing gait, flat facial expressions, increasing social isolation, a preponderence of self-stimulating activities such as body rocking and skin picking, and other such characteristics. It is clear that these characteristics are not a reflection of the disorder which is present; rather, they are a response to marked physical and emotional isolation—the twin hallmarks of the dehumanization process which thrives so well (unfortunately) in the large institutions. See D. Vail, Dehumanization and the Institutional Career (1966).

26. For a critical analysis of this period, see W. Wolfensberger, The Origin and Nature of Our Institutional Models, in Changing Patterns in Residential Services for the Mentally Retarded 59 (President’s Committee on Mental Retardation, 1969).
27. As recent as 1968, the persistence of these misperceptions could be seen in the rationale of the Nebraska Supreme Court in its upholding the required sterilization of mentally retarded citizens as a condition precedent to discharge from the state institution in State v. Cavitt, 182 Neb. 712, 157 N.W.2d 171 (1968). The Cavitt court stated:

It can hardly be disputed that the right of a woman to bear and the right of a man to beget children is a natural and constitutional right, nor can it be successfully disputed that no citizen has any rights that are superior to the common welfare. Acting for the public good, the state, in the exercise of its police power, may impose reasonable restrictions upon the natural and constitutional rights of its citizens. Measured by its injurious effect upon society, the state may limit a class of citizens in its right to bear or beget children with an inherited tendency to mental deficiency, including feeblemindedness, idiocy, or imbecility. It is the function of the Legislature, and its duty as well, to enact appropriate legislation to protect the public and preserve the race from the known effects of the procreation of mentally deficient children by the mentally deficient.

Id. at 715, 157 N.W.2d at 175.
28. A negative fallout of the lingering effects of the tragic interlude was that many of our institutions for the retarded (even to this day) have continued to operate in the spirit and knowledge of the 1920’s when the inexpensive segregation was viewed as the only possible mode for “treatment.” Yet the basis for this continuing momentum of the institutions is currently without scientific or social rationales. For example, modern genetic studies clearly illustrate that less than 15% of the cases of retarda-
Thus the initial enthusiasm, for "educating the mind of the idiot," had been replaced by the tragic interlude which brought with it nihilistic treatment and custodial approaches toward the mentally retarded. This has been attributed to genetic or chromosomal causes. See L. Hillard & B. Kirman, Mental Deficiency 73-79 (1965); N. Robinson & H. Robinson, The Mentally Retarded Child 51-108 (2d ed. 1976). Similarly, the documented improvement of social-behavioral aspects of mentally retarded citizens when they have been helped within the framework of their primary families and communities has put to rest the old "expected" problems of the mentally retarded in the areas of work, socialization and sex. See generally Skeels, Adult Status of Children with Contrasting Early Life Experiences, 31 Soc'y for Research in Child Dev. (Supp. 1966); R. Kennedy, A Connecticut Community Revisited: A Study of the Social Adjustment of a Group of Mentally Deficient Adults in 1948 and 1960 (1966).

Further, public attitudinal changes have taken on a positive tone. See K. Packard & B. Laveck, Public Attitudes, in Mental Retardation: Century of Decision 106 (President's Committee on Mental Retardation, 1976). Perhaps more important are the clear indications of the colossal failure of our current public institutions as an abode for any human being. See B. Blatt and F. Kaplin, Christmas in Purgatory (1966). It is these collective refutations of the tragic interlude which have prompted the current approaches to redeem both the past and present via the provision of futuristic-oriented services of normalized and developmentally oriented systems of care for our retarded citizens.

29. The way society views the mentally retarded has been a major factor in determining the location, design and program orientation of residential facilities. These basic role perceptions may be thought of in terms of service models. In this context, a service model for mentally retarded persons is a set of premises or predictions from which services are structured. In most cases, the total environmental setting reflects these predictions and there is no allowance for behavior or development contrary to such predictions. Thus, models generate self-fulfilling prophesies, i.e., the type of behavior or development predicted is encouraged and, generally, the expected results appear to be achieved. See W. Wolfensberger, The Origin and Nature of Our Institutional Models, in Changing Patterns in Residential Services for the Mentally Retarded 59, 63-143 (President's Committee on Mental Retardation, 1969).

Wolfensberger describes seven models for services which are frequently found in institutions in this country. The first six are destructive in nature, and have resulted in inappropriate and dehumanizing approaches to residential care. The developmental model is the only one which does not result in a dehumanizing approach to mental retardation. These models are:

1) The Sick Person—Mentally retarded persons are cared for in hospital-like setting as if they were ill or diseased. Dependency, safety, comfort, cleanliness, and emphasis on the physical aspects of the “patient” are typical.

2) The Subhuman Organism—Mentally retarded persons are viewed as being deviant to the extent of not being completely human, and are typically housed in an indestructible setting with locked doors. They are allowed minimum freedom and considered incapable of making decisions.

3) The Menace—Mentally retarded persons are viewed as a threat because of their differences. They live in a prison-like setting. Few provisions for safety are provided. Care techniques may bear overtones of persecution. There is an emphasis on segregating the sexes.

4) The Object of Pity—Mentally retarded persons are cared for as if
"menace in our midst." However, since the early 1960's there has been a distinct humanistic renaissance, replete with a new philosophy (normalization) and a distinct professional approach they were suffering victims. Responsible functioning is de-emphasized. The retarded are sheltered, made comfortable, and emphasis is placed on making them "happy and contented."

5) The Burden of Charity—Mentally retarded persons are viewed as being the responsibility of public charity, but it is assumed services will not exceed minimum expectations. The retarded are expected to be unduly grateful and suffer through intermittent hardships without complaint.

6) The Holy Innocent—Mentally retarded persons are viewed as innocent, harmless, childlike persons. Age is no criterion—even adults are treated as children.

7) The Developing Person—All mentally retarded persons regardless of their degree of retardation, are considered capable of growth and learning. The structure of the environment in which they live is also considered of prime importance in influencing the rate and direction of behavioral change.

30. This phrase was first used in F. Crookshank, The Mongol In Our Midst: A Study of Man and His Three Faces (1924).

31. The normalization principle advocates furnishing the retarded with patterns of life which are as much like the normal life style as possible. See B. Nirje, The Normalization Principle and Its Human Management Implications, in Changing Patterns in Residential Services for the Mentally Retarded 179 (President's Committee on Mental Retardation, 1969).

The principle of normalization has been interpreted to mean the use of management techniques that are as culturally normative as possible in an effort to elicit and maintain behavior which is consistent with local and subcultural differences in the mainstream of society. The principle reflects the professional posture that when we have a retarded person live as normal a life as he possibly can within as normal a setting as possible, a retarded person tends to live up to the normal expectations of the environment into which he has been placed.

The principle underscores that the retarded citizen should have a normal rhythm of day, normal rhythm of seasons, be permitted to experience the normal developmental challenges of the life cycle of growth, the right to make decisions and choices for one's self, the right to experience living in a bisexual world, the right to normal economic standards as to vocational endeavors, and finally, the right to live, work, and play in what is deemed normal and humane for that society. This concept embodies a philosophical position concerning the personal dignity and human rights of the individual, as well as encompassing a series of specialized program services that are located in the mainstream of society. Accordingly, the concept of normalization, when applied to the mentally retarded, refers to both an attitude and an approach to the individual which stresses his right to live a life as close to the normal as possible.

The attitudinal dimension stresses that the retarded have the same right to maximal developmental opportunities as do their fellow citizens. They are not to be considered "vegetables," "mongolian idiots," or "low level retardates," but rather as fellow human beings who have a variety of special problems in coping with the world around them. The normalization approach encompasses a positive posture of hope, challenge, and honesty about what can, must and will be done to help the retarded. See W. Wolfensberger, The Principle of Normalization in Human Services 6-29 (1972); Wolfensberger, The Principle of Normalization and Its Implications to Psychiatric Services, 127 Am. J. Psychiatry 291 (1970).
MENTAL HEALTH (the developmental model), toward treatment of the mentally retarded.

Perhaps the most noteworthy changes in the field of retardation have come with the embracing of the developmental model as the major prescriptive approach for treatment-management programs, and the gradual acceptance of the ideological principle of

32. The developmental model is based upon three primary assumptions:

1) **Life as change**—Man, like other life forms, is in a state of change from the time of conception until death. The assumption that mentally retarded persons are often fixed or unchanging physically and psychologically is, in effect, the same as denying that mentally retarded persons are alive.

2) **Sequential development**—The development of human beings progresses in a sequential, orderly, and predictable manner. Each sequence of development serves as an introduction for more or less complex functioning. Thus, developmental sequences can be identified and used in planning programs and assessing progress.

3) **Modifiable development**—The rate and direction of development are influenced by the interaction of many internal and external factors, including inherited characteristics, health and the external environmental setting.

The programs for mentally retarded citizens, based on these three aspects of the developmental model, are designed for the express purpose of modifying the rate and direction of behavioral change. Recognition of the fact that each retarded child or adult is in a continual state of change subject to the influence of dynamic encounters with the environment is basic to the concept. See generally P. Roos, G. Patterson & B. McCann, Expanding the Developmental Model (1970).

33. The developmental approach to mental retardation considers each individual as a unique, changing human being capable of growth, learning, and development.

The primary implication of the developmental approach is that progress oriented toward the individual and program goals should be dynamic and individually defined. Specific goals should be determined by observation of the individual's behavior and his current state of development. Equally important, is the implication that the rate and direction of behavioral change in relation to specific goals will be constantly re-evaluated in order that the individual may progress at the maximum possible rate.

Developmental programming is not limited to the early phases of the life cycle, but is applicable to all stages, including old age. During the later stages of life, or in the case involving organic deterioration, goals should be selected in terms of decelerating negative changes, while changes considered to be desirable are selected for acceleration. For example, a person afflicted with progressive paralysis of the legs should be helped to retain maximum muscle control (decelerating muscle atrophy and loss of functions) while learning new skills involving the use of mechanical devices, such as a wheelchair and crutches (accelerating new behaviors).

Therefore, future developmentally oriented programs for the mentally retarded must focus on selected areas for accelerating, decelerating or modifying both the direction and rate of learning and behavioral changes. The goal of the developmental model is to provide effective coping devices for the retarded citizen's inter-personal and physical environments. Reflect for a moment on how many of the current "lost generation" of the retarded have primitive behavioral repertoires because they are "untutored"—rather
normalization as an overall approach to the retarded. These relatively recent innovations represent key underpinnings of the modern treatment approaches for the mentally retarded and have facilitated a re-examination of personal, family, and social responsibilities as well as a re-examination of imperative civil and human rights which were not previously met for retarded citizens.

CURRENT TRENDS IN TREATMENT

Current trends can be synopsized by outlining the crucial dimensions of habilitating retarded citizens. Although the "what is treatment?" question has been approached quite differently, Full utilization of the developmental model will produce programs that: a) allow the retarded individual to increasingly develop control over his environment; b) increase the complexity of his behavior; c) extend his repertoire of interpersonal skills; and d) maximize his humanization. See generally F. Menolascino, OVERVIEW OF PROGRESSIVE IDEOLOGY IN MENTAL RETARDATION (1976).

34. Professor Wolfensberger has proposed that the normalization approach is: "[U]tilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." W. Wolfensberger, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 28 (1972).

35. In the past, commitment to an institution for the retarded was considered treatment in and of itself. Today, however, the approach consists of an initial diagnostic evaluation by a multidisciplinary team which spells out what therapeutic prescriptions are needed; then the services to meet these specific needs are coordinated for and with the individual. See R. Koch & K. Koch, UNDERSTANDING THE MENTALLY RETARDED CHILD 145-174 (1974); U. Haynes, The Cross Disciplinary—Cross Modality Approach to Services for the Developmentally Disabled Who Have Physical Handicaps, in BEYOND THE LIMITS 44 (F. Menolascino & P. Pearons eds. 1974); F. Menolascino, MENTAL RETARDATION: PROGRESSIVE IDEOLOGY AND SERVICES 296 (1976).

Treatment in the field of mental retardation in contrast to mental illness is much easier to delineate because a) the diagnosis is an operational one; and b) habilitation requires only a description of a retarded individual's current level of functioning without over concern as to the underlying cause. In contrast, the comparative ineffectiveness of long-term treatment approaches in mental illness is due to the fact that too much time, effort and attention are paid to elucidation of the possible mechanisms which are thought to be responsible, rather than employing more direct and creative approaches to advising parents, teachers, and the individual himself on how to handle his problems. In other words, the level of mental retardation (i.e., mild, moderate, severe) is more directly applicable to habilitation needs of the mentally retarded and thus more directly spelled out as to their medical, social, emotional and vocational needs, regardless of the cause of the symptom of mental retardation. See J. Tizard, Mental Retardation and Child Psychiatry, in PSYCHIATRIC APPROACHES TO MENTAL RETARDATION 615 (F. Menolascino ed. 1970).

During the last 20 years there has been a vigorous expansion of research
habilitation basically encompasses: (a) a detailed developmental assessment of a retarded individual's ability to cope with personal-social expectations at the differing developmental stages of life (e.g., infancy, childhood, adolescence, young adulthood, etc.), encompassing a survey of the physical, motor, language, social, and intellectual components of an individual's overall functioning; and (b) the provision of the specific services needed (e.g., educational, medical, physical therapy, etc.) to effectively alter the deficits identified by the developmental assessment.\(^3\)

The initial emphasis of modern habilitation is a concerted approach to the signs of developmental delay that are noted as a result of the developmental assessment, while specific symptom management is secondary.\(^3\) Thus the overall thrust of modern habilitation is the remediation of the delayed learning process so as to develop the maximum growth potential by the acquisition of

with the severely retarded concerned with the improvement in self-care and grooming techniques. Many individuals have been trained so that antisocial behaviors, autistic stereotyped movements and self-destructive behaviors have been successfully eliminated. This movement has represented a revolution in approach to the severely retarded. It was made possible by a fundamental change in concepts about behavioral development which had been taking place in the previous two decades. An emphasis on the notion that development is primarily a function of predetermined sequences of neurological change which are measurable and predictable, but not alterable, in important ways shifted to the concept that environmental stimulus during rearing could be critical both in retarding and promoting growth. The implication was that whatever happened to a person could affect his behavior in positive or detrimental ways. It is no longer necessary to regard the mentally retarded person as fixed at a particular level of functioning. Instead, one must ask whether their environment reduces their potential or promotes it. Perhaps the most succinct statement of this position has been that of William Bricker:

I wish to affirm my belief in the importance of the nervous system and to indicate a conviction that a host of events can do damage to it and to its functioning. However only the failure of a perfectly valid, perfectly reliable, perfectly efficient program of training will convince me that the identification of the deficit is sufficient reason to stop trying to educate the child. Bricker, *Identifying and Modifying Behavioral Deficits*, 75 *Am. J. Ment. Defic.* 16, 20 (1970).


37. Specific secondary symptoms such as seizures, visual or hearing disorders, and secondary emotional disturbances can be troublesome in the retarded individual's developmental progress. However, these symptoms can be readily managed by the community-based physician. See Pearson, *The Physician's Role in Diagnosis and Management of the Mentally Retarded*, 15 *Pediatric Clinics of North America* 835 (1968).
self-help, language, personal, social, educational, vocational, and recreational skills. Although the symptoms of mental retardation are well understood, the modern approach to habilitation emphasizes that neither the “old” medical model nor the current medical model is applicable to the treatment of mental retardation because the specific causes are unknown in 75 percent of the cases. Accordingly, the past and current medical models are inappropriate treatment approaches for a vast majority of retarded citizens and since the bulk of institutions for retarded citizens are based upon the current medical model, they are irrelevant ideologically or pragmatically as sites for the habilitation of retarded citizens.

To be most effective, habilitation must be initiated as early as possible. There is literally a mountain of early developmental knowledge that clearly underscores the vital importance of the first years of life (especially up to age 8 years) as the time wherein the bulk of basic human learning occurs. Early treatment intervention also carries with it a positive dimension of preventing associated disorders. For the young retarded child whose delayed intellectual development begins in the earliest years, every day is a critical period of brain growth and development. The rapidly enlarging central nervous system and the child’s “readiness” for learning have all been underscored by the dramatic results of home training programs wherein mothers can educate their retarded children early in life while at home. Indeed, the first 5 to 8 years of life have been termed the critical periods of development. The rapidly enlarging central nervous system and the child’s “readiness” for learning have all been underscored by the dramatic results of home training programs wherein mothers can educate their retarded children early in life while at home.

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39. See President’s Panel on Mental Retardation, A Proposed Program for National Action to Combat Retardation (1962); President’s Committee on Mental Retardation, Mental Retardation: Century of Decision (1976).
40. In the past the medical model was a symptom control approach: the treatment of “the fevers” of unknown causes (e.g., infectious diseases such as tuberculosis by rest, aspirin, etc.). More recently the modern medical model embodies a specific treatment (e.g., an antibiotic such as penicillin) for a specific set of symptoms stemming from a specific cause (e.g., infected throat produced by an isolated bacterium).
41. See generally J. Tizard, Community Services for the Mentally Handicapped (1964); L. Dunn, Small, Special-Purpose Residential Facilities for the Retarded, in Changing Patterns in Residential Services for the Mentally Retarded 211 (President’s Committee on Mental Retardation, 1969); Zigler, Balla & Watson, Developmental and Experimental Determinants of Self-Image Disparity in Institutionalized and Noninstitutionalized Retarded and Normal Children, in 23 J. Personality & Soc. Psych. 81 (1972); F. Menolascino, Changing Developmental Perspectives in Down’s Syndrome, 4 Child Psychiatry and Human Dev. 205 (1974).
42. Indeed, the first 5 to 8 years of life have been termed the critical periods of development. The rapidly enlarging central nervous system and the child’s “readiness” for learning have all been underscored by the dramatic results of home training programs wherein mothers can educate their retarded children early in life while at home. See generally S. Kirk, Early Education of the Mentally Retarded (1958).
43. A comprehensive bibliography of behavioral research on severe and profound mental retardation (currently in press) has clearly illustrated this point. See Bershon, Behavioral Research on Severe and Profound Mental Retardation, 81 Am. J. MENT. DEFIC. (In Press, 1976).
44. This dimension was clearly illustrated by a study of young infants
An intellectual level makes him already seriously "at risk" (i.e., in need of extra developmental stimulation), confinement in a depersonalized institutional setting characterized by high personnel turnover and multiple staff shifts deprives him of the needed warmth and personal contact at the most critical developmental period in his life, a deprivation which is usually not reversible.45

The place of implementation becomes important when one analyzes the rationales for placing retarded citizens in institutions. A study by Dr. F.J. Menolascino clearly illustrates the irrational persisting approach of institutionalizing mentally retarded citi-

whose mothers had contacted Rubella (German measles) during the first three months of pregnancy. These youngsters all had major handicaps (e.g., small head circumference (microcephaly), blindness, mild hearing loss, and mental retardation). The authors noted that in those infants whose mothers and/or visiting nurses provided a stimulating environment (e.g., loud speech, fondling and tactile stimulation, etc.), early and positive emotional contact with those around them occurred and the infants developed quite well.

In contrast, similar infants who had not had such early stimulation became withdrawn, had "blindisms" (e.g., aimless, solitary hand play near their eyes for hours) and showed major developmental delays. This study clearly shows the need to initiate modern treatment as early as possible or there may not be another opportunity to effectively aid the child's development. See S. Chess, S. Korn & P. Fernandez, Psychiatric Disorders of Children with Congenital Rubella (1971).

45. In early personality development, the effects of early parental loss and institutionalization have had a markedly negative effect on children. See generally R. Spitz, Hospitalism: An Inquiry Into the Genesis of Psychiatric Conditions in Early Childhood, 1 Psychoanalytical Study of the Child 53 (1945); J. Bowlby, Maternal Care and Mental Health (1951). As recently as ten years ago some of the most familiar sights in institutions for the retarded were the detached, mildly to moderately retarded individuals. These persons tended to manifest two basic expressions of the syndrome of detachment. One was the child with chronic relationship hunger who would indiscriminately approach any visitor in a pathetic attempt to gain attention. The other was the child who had given up on reaching people and would withdraw to spend countless hours in some type of ritualized, often bizarre, self-stimulating behavior. These two types of behavior were for years often cited as "reasons" to continue institutional care. The lesson clearly learned from the work of Spitz and Bowlby was that to a large extent, the impersonal care of the institution had led to these behavioral characteristics of detachment.

As the newer principles of care have been directly applied, it has become increasingly apparent that much of the behavior thought to be most typical of the retarded person had been actually an expression of emotional detachment, and was therefore preventable through placing retarded children in small settings where they had a limited and consistent group of caretakers. More recent attention to these critical developmental periods and events have underscored the importance to children of this type of care for acquiring and sustaining higher levels of competence. See generally K. Connolly & J. Bruner, Competence: Its Nature and Nurture
In a group of youngsters with Down's Syndrome (mongolism) the study revealed that they had been institutionalized for three main reasons: 1) lack of educational opportunities; 2) family crisis; and 3) behavior problems. Each of these three "problems" could have been treated in their home communities more efficiently, more effectively, more conducive to their current-future growth, and without the feature of a restrictive environ-


46. The study was of a relatively large (72) group of retarded young adults with Down's Syndrome (individuals who are usually in the moderate level of mental retardation). The major hypothesis of the study was that individuals with Down's Syndrome have much higher developmental expectations than are generally reflected in the current literature. This hypothesis was studied by assessing the current developmental attainments of a randomly selected sample of mature individuals with Down's Syndrome at a large public residential facility for the mentally retarded. Five areas of developmental attainment were investigated: ambulation, feeding, dressing, toilet training and grooming.

Overall, the levels of functioning noted were not consistent with the prevailing beliefs that Down's Syndrome prevents one from attaining a rather advanced repertoire of self-help skills. For example, in ambulation the results indicated that, as a whole, members of this sample were able to walk without assistance of any type. To the reader, this might appear as a somewhat elementary and unsophisticated accomplishment, but it nevertheless denies one of the primary suppositions of custodial or institutional care, that of the staff "wheeling the patient" or otherwise needing to aid the resident in this area. Sadly, the overwhelming majority of the sample were generally confined to the widely used institutional concept of the "lowest common denominator" wherein only a limited number of options were available to them for fully utilizing or further embellishing their ambulatory potentials.

The presence of Down's Syndrome is often erroneously equated with severe and/or "hopeless" retardation, and a very low level of functioning self-help skills is expected. Yet, it is clear that the overwhelming majority of the patients evaluated in this study were able to master those developmental attainments that constitute the core of self-help care, despite the negative self-fulfilling prophecy that brought them to the institutions early in their lives. See F. Menolascino, Changing Developmental Perspectives in Down's Syndrome, 4 Child Psychiatry and Human Dev. 205 (1974).

The data in this study was compiled at an institution for the mentally retarded that was actively being investigated by a Governor's Committee on Mental Retardation. The amount of developmental stimulation received by the residents at this institution was described by the committee as shockingly and grossly insufficient. See Wolfensberger and Menolascino, Reflections on Recent Mental Retardation Developments in Nebraska, 8 Ment. Retard. 20 (1970). Accordingly, the findings in this particular sample may reflect an underestimation of possible developmental performance and/or attainment of mature individuals with Down's Syndrome. The relatively high level of self-help skills demonstrated in this study was obtained under very adverse conditions. If this institution had been adequately staffed and developmental programming actively pursued, we could surmise that a larger percentage of the sample would probably have attained higher levels of self-help skills.
ment. Thus, modern habilitation of mentally retarded citizens must be implemented in the mainstream of his or her community, utilizing the generic developmental services provided for their non-retarded brothers and sisters.

In the past, the diagnosis of mental retardation was often offered simultaneously with a calamitous prognosis without any concerted effort to assess the role and/or benefits of developmental approaches which focus on normalized stimulation. The mixed challenges of the unknown-known developmental aspects of mental retardation have all too often been ignored in favor of the professional posture of institutionalization. Similarly, questions about future attainments were commonly answered by suggesting prompt institutionalization to parents or guardians. The literal trading of the individual's right to developmental maximization for the family's well-being, both of which are factors in this mode of "treatment" recommendation, has been too long viewed as unimportant.

One vital recent development obviates the use of traditional institutions as a treatment or educational milieu for retarded individuals—community-based alternatives that can provide increasing opportunities for self-fulfillment. Community-based services allow the individual to retain his family environment while providing the family with community resources at predetermined critical points in the retarded person's development.

As the literature of normalization began to awaken parents to the artificial nature of life in an institution and to the promise of


48. See generally B. Lensink, One Service System that Works, in New Neighbors: Retarded Citizens in Quest of a Home (C. Cherrington & G. Dybwad eds. 1974); F. Menolascino, Mental Retardation: Progressive Ideology and Services 263-93 (1976); President's Committee on Mental Retardation, People Live in Houses (1975).

49. Recommending early institutionalization for the child with Down's Syndrome as a "treatment" for his developmental needs continues to be a common practice past and present. See Aldrich, Preventive Medicine and Mongolism, 52 AM. J. MENT. DEFIC. 127 (1947); D. Braginsky & B. Braginsky, Hansels and Gretels: Studies of Children in Institutions for the Mentally Retarded (1971); P. Morris, Put Away (1969); Kelly & Menolascino, Physicians' Awareness and Attitudes Toward the Retarded, 13 MENT. RETARD. 5 (1975).

50. See generally B. Lensink, One Service System that Works, in New Neighbors: Retarded Citizens in Quest of a Home (C. Cherrington & G. Dybwad eds. 1974); F. Menolascino, Mental Retardation: Progressive Ideology and Services 263-93 (1976); President's Committee on Mental Retardation, People Live in Houses (1975).
development for their child,\textsuperscript{51} parents of mentally retarded children in Nebraska advocated the establishment of a Governor’s Citizens’ Committee on Mental Retardation.\textsuperscript{52} Armed with the belief that mentally retarded citizens could function within their own community if provided with the necessary services within that community, the Governor’s Committee outlined in their report a system of services wherein mentally retarded citizens could “make it” in their own communities.\textsuperscript{53} This parent-inspired report resulted, in 1969, in the establishment of a statewide system of community-based services for mentally retarded citizens in Nebraska.\textsuperscript{54}

The state is divided into six mental retardation regions and each county within the state is authorized to provide or contract for services either individually or through one of the six regional offices.\textsuperscript{55} The Eastern Nebraska Community Office of Retardation (ENCOR) is one of Nebraska’s six regions.\textsuperscript{56} ENCOR provides a comprehensive continuum of services at the local level so that necessary services can be provided without the individual leaving the ENCOR region.\textsuperscript{57}

All ENCOR services are premised upon the principle of normalization and strive to provide each retarded citizen with the opportunity for optimum life within the individual’s community.\textsuperscript{58} A primary purpose of ENCOR has been the advancement of “mentally retarded persons to the use of the same educational, vocational, residential and other social environments available to all citizens within a community independent of ENCOR support.”\textsuperscript{59}

\textsuperscript{51} Address by E. Elkin, National Conference on Mental Retardation, Nov. 1974.
\textsuperscript{52} See generally 1 THE REPORT OF THE NEBRASKA CITIZENS STUDY COMMITTEE ON MENTAL RETARDATION (1968).
\textsuperscript{53} Id.
\textsuperscript{54} The State Office of Mental Retardation is authorized to contract with public or private agencies for mental retardation service delivery and administration. Neb. Rev. Stat. §§ 83-1,141, -1,146 (Reissue 1971).
\textsuperscript{55} Neb. Rev. Stat. §§ 23-2,201-2,207 (Reissue 1974). This act, known as the Interlocal Cooperation Act, authorizes two or more governmental units to join together for one or more functions. Neb. Rev. Stat. §§ 23-104.03 (Reissue 1974) specifically authorizes counties, individually or through the Interlocal Cooperation Act, to provide by contract for services for mentally retarded citizens as well as other groups.
\textsuperscript{56} ENCOR was established on July 1, 1970 as a joint venture between five counties in the eastern portion of Nebraska.
\textsuperscript{57} See generally [1973-74] EASTERN NEBRASKA COMMUNITY OFFICE OF RETARDATION ANNUAL REPORT.
\textsuperscript{58} Id.
\textsuperscript{59} Id. at 1.
To accomplish this purpose ENCOR is set up into three program divisions: developmental and vocational programs, residential services, and family resource services. Developmental programs provide individualized progression types of educational programs for all ages. Vocational programs emphasize progression of the individual toward competitive employment. Residential services provide alternative living and support settings which range from emergency crisis homes to group residences and various individualized alternative living units. Family resource services

60. Id. at 5-13. Developmental programs are directed toward progressing an individual into the public or private school systems. Developmental centers work with children up to 12 years of age who have been excluded or prevented from attending public or private schools. The centers are geared to meet individual needs in the areas of language, development, motor development, socialization, self-care development and academic development. Coordinated Early Education Program takes small groups of pre-school mentally retarded children and with the assistance of an ENCOR resource teacher enrolls those children in regular pre-school programs. These integrated settings provide opportunities for mentally retarded children to learn from children of their own age group. An adolescent education program, designed for the mentally retarded youngsters up to 18 years of age who have been denied public school admittance, provides language development, motor development, self-care, group interactions, pre-work skill development and community access experiences. Children, who are severely and profoundly retarded with complex medical problems, are provided a combination residential and medical setting which also continues educational and developmental activities aimed at self-help skills, ambulation and social personal awareness. The developmental maximization unit is considered a temporary placement which "graduates" children into more normalized residential and educational settings at the earliest opportunity. Id.

61. Id. at 14-15. Five industrial training centers within the ENCOR region serve approximately 190 mentally retarded trainees at any one time. These centers train individuals over 16 years of age for integration into employment generated by local industry. Work Stations in Industry offers specific skill training for community business or industry employment. In addition to developing skills which are prerequisites for employment, the individual also develops self-help skills in the use of community transportation services. In conjunction with vocational training, evening classes are offered at community facilities to further develop skill in academic and job-related areas. Since 1970, over 200 mentally retarded adults have been placed in competitive community employment by ENCOR. Id.

62. Id. at 16-19. Whenever possible families are provided with support services which permit the mentally retarded citizen to remain within his or her home. When the individual cannot live in the family home a residential setting which is as normalized as possible is provided. Group residences for children and group residences for adults (serving from six to twelve persons at a residence) are home-like settings where independent living skills such as cooking, cleaning, laundry, shopping, budgeting and socializing are developed. Alternative Living Units for six or fewer persons are a more normalized and individualized type of residence which includes homes, apartments, condominiums and townhouses. All living situations provided by ENCOR must meet licensing standards regulated by the local, state and federal governments. Id.
provide professional services for the retarded and their families as well as consultative support to the ENCOR staff. While the foregoing description of ENCOR does not address the question of whether it actually delivers modern services to mentally retarded citizens, the efficacy of ENCOR has been described in a number of recent studies and publications. The general consensus of these studies is that ENCOR has been highly effective in providing mentally retarded citizens with necessary services within the mainstream of the society where they live.

Thus, the ideology of normalization and the developmental model formulated during the 1960's reshaped professional perceptions regarding mentally retarded citizens. The evolving professional perceptions focused upon eradication of the destructive models underpinning the residential institutional approach to mentally retarded citizens. Mental retardation professionals soon realized that application of normalization principles demanded less restrictive integrated settings which could never be achieved within the confines of massive residential institutions. Alternative systems of services were created reflecting the new perceptions.

As the disparity grew between what was (custodial institutional care) and what was evolving (community-based programs), mentally retarded citizens turned to the judicial branch, as had other minorities before them, for recognition and protection. The judicial response in the 1970's, by utilizing concepts of

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63. The services provided through Family Resource Services include intake counseling, psychological and medical services, speech and physical therapy, transportation, recreation and records. Id. at 20-23.

64. Id. at 20.


66. See note 29 supra.

67. See National Association for Retarded Citizens, The Right to Choose (1973); President’s Committee on Mental Retardation, People Live in Houses (1975); See also C. Cherrington & G. Dybwad, New Neighbors: Retarded Citizens in Quest of a Home (1974); F. Menolascino, Mental Retardation: Progressive Ideology and Services (1976).


69. See L. Miller, The Petitioners (1966); Symposium—Women and
substantive due process and the prohibition against cruel and unusual punishment, in union with the evolving professional perceptions and principles in mental retardation, focused upon the conditions of confinement in institutions, as had the professionals in mental retardation in the 1960's. The initial formulation of a due process right to habilitation, when analyzed, may be viewed as a limited reaction to dehumanizing and degrading conditions present within the institutions.

RECOGNITION OF THE DEVELOPMENTAL MODEL—RIGHT TO HABILITATION

The seminal formulation of a constitutional right to habilitation for mentally retarded citizens involuntarily confined in a state institution appeared in Wyatt v. Stickney. The right to habilitation for involuntary confined mentally retarded citizens

The use of the concept “habilitation” instead of “treatment” in the context of mental retardation reflects an awareness that “mental illness” is not synonymous with “mental retardation.” Mental illness concerns an inability to cope with one’s environment regardless of intellectual level. Mental illness can occur at any stage of life while mental retardation is considered to be a developmental disability beginning in the early years. See the Law, 23 Hast. L. J. 1-316 (1971); L. Kanowitz, Women and the Law 160-96 (1969).


The doctrine of the right to habilitation was recognized for mentally retarded citizens who were involuntarily committed to the state institution. However, since the state failed to adduce any evidence showing that any resident was voluntarily confined the court presumed all residents were entitled to constitutionally minimum habilitation. Wyatt v. Stickney, 344 F. Supp. 387, 390 n.5 (M.D. Ala. 1972).

For many mentally retarded citizens involuntary commitment is usually a formality; most institutional residents have not been formally committed but “voluntarily” placed by their parents, relatives or guardians. To regard the decision by the parent or guardian as the equivalent of the consent of the retarded person is to fail to perceive the conflicting interests at work. Recognizing this possible conflict, the court in Horacek v. Exon, 357 F. Supp. 71, 74 (D. Neb. 1973) appointed a guardian ad litem to alert the court to potential and actual differences in positions asserted by parents and positions that need to be asserted on behalf of the plaintiffs during the pendency of the litigation. See text at notes 46-47 supra. See also Herr, Civil Rights, Uncivil Asylums and the Retarded, 43 U. Cin. L. Rev. 679, 708-25 (1974); Kay, Farnham, Karren, Knakal & Diamond, Legal Plan-
followed on the heels of an earlier decision by the same court establishing a right to treatment for involuntarily committed mentally ill.75

Substituting "habilitation" for "treatment," the Wyatt court noted:

In the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded. Because the only constitutional justification for civilly committing a mental retardate, therefore, is habilitation, it follows ineluctably that once committed such a person is possessed of an inviolable constitutional right to habilitation.76

The court in Wyatt defined "habilitation" as:

[T]he process by which the staff of the institution assists the resident to acquire and maintain those life skills which


76. The genesis for the concept of the "right to treatment" appeared with Dr. Morton Birnbaum's thesis that if society sought to deprive an individual of his liberty in order to provide care and treatment, courts should ensure that such treatment is provided. Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960). Birnbaum's thesis received judicial recognition in Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). Judge Bazelon, while premising the right for treatment on statutory grounds, suggested in dicta that failure to provide treatment could raise serious constitutional questions of due process, equal protection and cruel and unusual punishment. Id. at 453. For a discussion of the debate spawned by the Rouse decision, see A Symposium: The Right to Treatment, 57 GEO. L.J. 673 (1969); Note, The Nascent Right to Treatment, 53 VA. L. REV. 1134 (1967); Note, Civil Restraint, Mental Illness and the Right to Treatment, 77 YALE L.J. 87 (1967); Katz, The Right to Treatment—An Enchanting Legal Fiction, 36 U. CHI. L. REV. 755 (1969); Bazelon, Implementing the Right to Treatment, 36 U. CHI. L. REV. 742 (1969). See also Nason v. Superintendent of Bridgewater State Hosp., 353 Mass. 604, 223 N.E.2d 908 (1968); Dobson v. Cameron, 383 F.2d 519 (D.C. Cir. 1967).

77. 344 F. Supp. at 390.
enable him to cope more effectively with the demand of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Thus, Wyatt implicitly accepted the concepts of the developmental model and its premises that all mentally retarded citizens, regardless of their degree of retardation, are capable of growth and learning; and that learning proceeds in a sequential fashion which is modifiable by the environment, and the interaction with staff, family, and peers.

This judicial recognition of the developmental model as the factual basis for the right to habilitation signals that mere custodial care as the primary function of institutionalization has reached a denouement. In Wyatt, a federal court finally recognized the growth potential of mentally retarded citizens and was requiring a custodial state institution to provide an environment to develop that potential, as a matter of constitutional law, as its primary function. Wyatt carefully etched out the parameters of the constitutional obligation imposed upon the institution. The Wyatt court found the essential minimum preconditions to habilitation to be (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized habilitation plans for each resident.

Implementing these preconditions of habilitation the Wyatt court approved 35 objectively measurable standards. Underlying the standards rectifying the physical facilities of the institution that prevented overcrowded, dehumanizing, substandard living con-

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78. Id. at 395.
80. 344 F. Supp. at 395. The growth potential of mentally retarded citizens gained additional recognition in Pennsylvania Ass'n for Retarded Children v. Commonwealth of Pennsylvania, 343 F. Supp. 279 (E.D. Pa. 1972) [hereinafter cited as PARC]. The fact is that among every 30 retarded children, 29 with a proper program of education and training have the potential to achieve self-sufficiency; 25 in the ordinary marketplace; 4 in a sheltered environment. The remaining 1 of every 30 with a proper program of education and training is capable of achieving a significant degree of self-care. Id. at 296.
82. Id. The Wyatt standards were drawn from various published standards: Accreditation Council for Facilities for the Mentally Retarded, Standards for Residential Facilities for the Mentally Retarded (1971) [hereinafter cited as ACFMR standards]; National Association for Retarded Children, Policy Statements on Residential Care (1968); President's Committee on Mental Retardation, Residential Services for the Mentally Retarded (1970); American Association on Mental Deficiency, Standards for State Residential Institutions for the Mentally Retarded (1964).
ditions was the modern emphasis of the developmental model upon the modifiability of behavior by the environmental setting. Thus Wyatt recognized the developmental model's premise that habilitation cannot proceed in a deteriorated and deprived physical environment. The standards requiring the institution to recognize each such resident's right to privacy, freedom from physical restraint, retention of private possessions, association with members of the opposite sex, and wearing of their own clothes reflected the philosophical basis of the principle of normalization while emphasizing the personal dignity of the mentally retarded citizen and rejecting the former destructive models.

Elaborating upon the individualized habilitation plan for each resident, the Wyatt court mandated the following standards to be constitutionally required to ensure habilitation: (1) a statement of the least restrictive habilitation conditions necessary to achieve the purposes of commitment; (2) a description of intermediate and long-range habilitation goals, with a projected timetable for their attainment; (3) a statement and rationale for the plan of habilitation for achieving these intermediate and long-range goals; (4) a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these habilitation goals; (5) criteria for release to less restrictive habilitation conditions; and (6) criteria for discharge.

The standards for implementation of individualized treatment plans not only utilize the developmental model's emphasis upon individualized program goals, based upon the identified and assessed needs of the person, the methods of achieving those goals and periodic review of both the goals and methods, but provided the court with objective measurable criteria for compliance.

83. 344 F. Supp. at 404-05.
84. See note 32 supra.
85. Wyatt had recognized that an "atmosphere of psychological and physical deprivation, is wholly incapable for furnishing [habilitation] to the mentally retarded and is conducive only to deterioration and debilitation of the residents." 344 F. Supp. at 391, quoting Wyatt v. Stickney, Unreported Interim Emergency Order (M.D. Ala. March 2, 1972).
86. 344 F. Supp. at 399-404.
87. See note 31 supra.
88. See note 29 supra.
89. 344 F. Supp. at 397-99.
90. See note 32 supra.
91. The adoption of standards by the Wyatt court weakened considerably the past contention that "adequacy of treatment" was a nonjusticiable question and beyond the competency of the judiciary because of the lack of manageable standards. The Department of Health, Education and Welfare in 1973 promulgated regulations detailing requirements for continued
Wyatt was cognizant of the substantial evidence that institutionalization is a disfunctional response to mental retardation since confinement in the institutional setting itself contributes to maladaptive social behavior, one of the indicia of mental retardation. Accordingly, Wyatt sought to apply the principles of normalization in an institutional setting by formulating that the right to habilitation must exist in the least restrictive setting:

Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into community living; (6) dependent to independent living.

The constitutional basis for the right to habilitation formulated by the Wyatt court proceeds with an acknowledgment of the indisputable fact that civil commitment is confinement entailing a massive curtailment of liberty in the constitutional sense. This curtailment of liberty, prohibited by the fourteenth amendment without due process of law, must be justified in terms of some permissible purpose.

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funding of intermediate care facilities for the retarded under the Medicaid Program. Social Security Act, Tit. XIX, 42 U.S.C. § 1396 (1970); 45 C.F.R. 234, 248, 249, 250 (1975) (hereinafter cited as ICFMR Standards). The ICFMR Standards, similar to the Wyatt standards, supply additional national standards in which to measure the adequacy of treatment. The Supreme Court in O'Connor v. Donaldson, 422 U.S. 563, 574 n.10 (1975), characterized the argument that the question of adequacy of treatment is non-justiciable, as unpersuasive and unacceptable. See also Wyatt v. Aderholt, 503 F.2d 1305, 1314 (5th Cir. 1974).

92. 344 F. Supp. at 391 n.7.
95. "[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." Jackson v. Indiana, 406 U.S. 715, 738 (1972). See also Tribe, Forward: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1, 16-17 (1973).
The only constitutionally permissible purposes for such a curtailment of liberty are the fulfillment of the state's parens patriae interest and/or the effectuation of its police power objectives. Since the purpose for confinement of the mentally retarded citizen is the parens patriae rationale, the Wyatt court formulated the rationale:

 Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense." (citation omitted).

The Wyatt court's substantive due process basis for the right to habilitation was developed and elaborated by the Fifth Circuit Court of Appeals' decision in Donaldson v. O'Connor. In Donaldson, the Fifth Circuit provided alternative rationales for such a due process right. The first rationale utilized by the Fifth Circuit in Donaldson relied upon the rule established by the Supreme Court in Jackson v. Indiana: "[A]t least, due process requires that the nature and duration of commitment bear some


97. The state as sovereign possesses the power to legislate for the protection of the public, health, safety, welfare and morals. See Developments in the Law—Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1222-44 (1974).

98. 344 F. Supp. at 390. The Wyatt court had previously stated: To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.


100. 493 F.2d 507 (5th Cir. 1974), rev'd, 422 U.S. 563 (1975).

101. Id. at 518-29. Donaldson involved a civil rights claim by a patient involuntarily committed under civil commitment procedures to a state hospital for the mentally ill. The Fifth Circuit upheld a jury award of $38,500 damages while holding that the patient had a constitutional right to such treatment as would help him to be cured or improve his mental condition. Id. at 527. Although the Supreme Court in O'Connor v. Donaldson, 422 U.S. 563 (1975) vacated the judgment and remanded the case to the Fifth Circuit Court of Appeals, the rationale of the circuit court merits an examination.

102. 493 F.2d at 521. Jackson v. Indiana, 406 U.S. 715 (1972), involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial. Since the mental and physical defects which were the cause of his inability were not susceptible to treatment and not likely to improve during his confinement, it was unlikely
reasonable relation to the purpose for which the individual is committed." Thus, if the purpose of the commitment is treatment under the parens patriae power, and treatment is not provided, then the "nature" of the commitment bears no "reasonable relation" to its "purpose" and the confinement is violative of the Jackson rule.

Clearly, under the first rationale for the right to habilitation, the court of appeals in Donaldson reasoned that the Jackson "permissible purpose" rule acted as a restraint upon the arbitrary exercise of parens patriae power and that failure to provide treatment would be arbitrary. Alternatively, the court of appeals, drawing no distinction between individuals committed under parens patriae rationales and those committed under police power rationales, reasoned that due process imposes specific limitations upon the government's power to detain and when confinement occurs in the absence of those limitations, treatment was the responsibility society assumed for the protection it derived from the denial of the individual's liberty. This quid pro quo formulation recognizes that the commitment process has undermined traditional criminal justice deterrents to oppressive confinements and where the state justifies confinement of a retarded citizen on the police power basis, instead of the traditional parens patriae basis, treatment would be required as the quid pro quo.

In Wyatt v. Aderholt, the Fifth Circuit Court of Appeals reaffirmed the quid pro quo rationale and rejected the state's
argument that the "need to care" for the mentally retarded and to relieve their families, friends, or guardians of the burdens of doing so can supply a constitutional justification for civil commitment.\textsuperscript{110}

The constitutional right to habilitation, its rationale and factual underpinnings was given added strength in the recent decision of \textit{Welsch v. Likins:}\textsuperscript{111}

\textit{[D]ue process requires that civil commitment for reasons of mental retardation be accompanied by minimally adequate treatment designed to give each committed person "a realistic opportunity to be cured or to improve his or her mental condition."}\textsuperscript{112}

The constitutional obligation imposed by the \textit{Welsch} court reaffirmed the prior judicial acceptance of the developmental model in \textit{Wyatt:}

The evidence in the instant case is overwhelming and convincing that a program of "habilitation" can work to improve the lives of Cambridge's residents. Testimony of experts and documentary evidence indicate that everyone, no matter the degree or severity of retardation, is capable of growth and development if given adequate and suitable treatment.\textsuperscript{113}

In a subsequent opinion, the \textit{Welsch} court adopted the principle of normalization within an institutional setting while determining the scope of the right to treatment and the remedies needed for implementation:

The expert testimony showed that improvements in the intellectual capacities and functional abilities of retarded persons may be accomplished through a comprehensive program of care and treatment known as "habilitation." A basic component of the habilitation process consists of the application of the principles of "normalization" by which the living conditions, appearances, and activities of mentally retarded persons should generally approximate those found in the rest of society. This means that, unless disabilities of the individual resident dictate otherwise, he should participate in training programs conducted outside resident living areas; eat or be fed, unless bedridden, in established dining areas; participate in planned, supervised outdoor recreational activities on a year-round basis; be provided with, and have access to, individual storage space for personal belongings; and be afforded normal privacy for bathing, toileting and dressing.

\textsuperscript{110} 493 F.2d at 1312-13.
\textsuperscript{111} 373 F. Supp. 487 (D. Minn. 1974).
\textsuperscript{113} \textit{Id.} at 495.
At least for the severely and profoundly retarded, this program of habilitation and normalization should be carried on consistently during the waking hours. This would enable skills learned in formal training programs to be continued and reinforced during portions of the days during which there are no formal programs or activities.\textsuperscript{114}

\textit{Welsch}, like \textit{Wyatt}, recognized the state's constitutional obligations flowing from the due process clause to provide habilitation in the least restrictive setting. The \textit{Welsch} court, while recognizing such a constitutional right, did not mandate the immediate transfer or require the formulation of a court order plan to implement the constitutional right.\textsuperscript{115} Seizing upon the "hospital transformed into a penitentiary" aspect of commitment absent treatment, the \textit{Welsch} court based its rationale for a right to habilitation upon both substantive due process and the prohibition against cruel and unusual punishment.\textsuperscript{116}

Acknowledging that treatment is the only permissible purpose for confinement of mentally retarded citizens, and applying the Supreme Court's decision in \textit{Robinson v. California}\textsuperscript{117} proscribing criminal incarceration for a status offense to various noncriminal incarceration, the \textit{Welsch} court reasoned:

The plaintiffs in the instant action are not criminals; they are victims of uncontrollable status.

If they are subject to "detention for mere illness—without a creative program," \textsuperscript{citation omitted}, plaintiffs will be within the ambit of the \textit{Robinson} proscription. While \textit{Robinson} turned on the Eighth Amendment, in the context of civil commitment in the instant case it is the due process clause that would compel that minimally adequate treatment be afforded the plaintiffs.\textsuperscript{118}

The constitutional obligation to provide habilitation in a normalizing setting that \textit{Wyatt} and \textit{Welsch} thrust upon the institution

\textsuperscript{114} Welsch v. Likins, No. 4-72 Civil 451, at 5 (D. Minn. Oct. 1, 1974).
\textsuperscript{115} \textit{Id.} at 28-31.
\textsuperscript{116} \textit{Id.} at 11. One federal court recently held that residents of a state institution for the mentally retarded have a constitutional right to freedom from harm founded in the Eighth and Fourteenth Amendments. New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 764 (E.D.N.Y. 1973). For criticism of the limited freedom from harm right see Halpern, \textit{The Right to Habilitation}, in \textit{The Mentally Retarded Citizen and The Law} 385, 402-04 (The President's Committee on Mental Retardation, 1976).
\textsuperscript{117} 370 U.S. 660 (1962). In \textit{Robinson}, the Supreme Court held that incarceration for the crime of being a narcotics addict was unconstitutional under the Eighth and Fourteenth Amendments since the sanction was imposed not for an act but for mere status. \textit{Id.} at 666-67.
\textsuperscript{118} 373 F. Supp. at 496.
received impetus from the Supreme Court's decision O'Connor v. Donaldson.\textsuperscript{119} Although the Supreme Court in Donaldson declined to decide whether a right to treatment for the mentally ill exists upon confinement and whether the \textit{parens patriae} purpose of commitment for the treatment is constitutionally permissible,\textsuperscript{120} Mr. Justice Stewart, speaking for the Court, held that mere custodial care can never justify the involuntary confinement of harmless mentally ill individuals.\textsuperscript{121}

The import of the Donaldson holding upon the vast number of mentally retarded citizens who are mildly and moderately retarded and able to function independently with a minimum of assistance is significant.\textsuperscript{122} Considered in the context of the modern understanding of mental retardation and the habilitative nature of community programs, continual confinement in an institutional setting is inconsistent with the constitutional right of every man to liberty. The Court in Donaldson stated:

\begin{quote}
[A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.\textsuperscript{123}
\end{quote}

Although Wyatt and Welsch are significant in their recognition of the principles of normalization and the developmental model for the factual foundation of their formulation of the constitutional right to habilitation, their approach can be considered only the rudimentary beginning. The logic of normalization and the developmental model which Wyatt and Welsch recognized suggests full implementation of habilitation can only be achieved in a non-institutional setting. Institutions, by their very structure—a closed and segregated society founded on obsolete custodial models—can rarely normalize and habilitate the mentally retarded citizen to the extent of community programs created and modeled upon the normalization and developmental approach components of habilitation. Neither Wyatt nor Welsch fully implemented the right to habilitation in that they failed to challenge the very existence of the institution. Consequently, the two institutional characteristics most antithetical to the application of the normalization principle

\textsuperscript{119}. 422 U.S. 563 (1975).
\textsuperscript{120}. \textit{Id.} at 573.
\textsuperscript{121}. \textit{Id.} at 575.
\textsuperscript{122}. \textit{See} F. Menolascino \& P. Pearson, \textit{Beyond the Limits} (1974); President's Committee on Mental Retardation, \textit{Silent Minority} 14-17 (1973); \textit{See also} D. Braginsky \& B. Braginsky, Hansels and Gretels: \textit{Studies of Children in Institutions for the Mentally Retarded} (1971); P. Morris, \textit{Put Away} (1969).
\textsuperscript{123}. 422 U.S. at 576.
MENTAL HEALTH

remain intact: segregation from the community and the total sheltering of retarded citizens in all spheres of their lives.\textsuperscript{124}

The immediate consequence of the continued segregation is that vestiges of the former destructive models of a mentally retard-
ed citizen as an “object of pity,” “a menace,” “a danger to himself and society,” continue to linger.\textsuperscript{125} The reaffirmance of these perceptions lengthens the time that the continued application of \textit{parens patriae} unnecessarily restricts the mentally retarded citizen’s exercise of such personal rights as: the right to marry,\textsuperscript{126} the right to sexual freedom outside marriage,\textsuperscript{127} the right to bear children,\textsuperscript{128} the right to raise children, and the right to family life;\textsuperscript{129} such civil and commercial rights as the right to contract for goods and property, the right to work; and such governmental participation rights as right to vote, hold office, and serve on a jury.\textsuperscript{130}

Likewise, the \textit{Wyatt} and \textit{Welsch} courts’ reliance upon elaborate standards for staffing ratios and physical facilities not only reinforces the total sheltering of retarded citizens in all spheres of their lives, but it raises the distinct possibility of further legitimatiz-

\textsuperscript{124} See note 31 \textit{supra}.
\textsuperscript{125} See note 29 \textit{supra}.
\textsuperscript{126} See \textit{Loving v. Virginia}, 388 U.S. 1 (1967), where the Court stated: “The freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness of free men.” \textit{Id.} at 12.
\textsuperscript{127} See \textit{Eisenstadt v. Baird}, 405 U.S. 438 (1972), where the Court stated: “If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” \textit{Id.} at 453.
\textsuperscript{128} See \textit{Skinner v. Oklahoma}, 316 U.S. 535 (1942), where the Court stated: “We are dealing . . . with . . . one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.” \textit{Id.} at 541.
\textsuperscript{129} See, e.g., \textit{Stanley v. Illinois}, 405 U.S. 645 (1972), where the Court stated:
The Court has frequently emphasized the importance of the family. The rights to conceive and raise one’s children have been deemed “essential” . . . “basic civil rights of man” . . . and “[r]ights far more precious . . . than property rights” . . . “It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder”. . . . The integrity of the family unit has found protection in the Due Process Clause of the Fourteenth Amendment . . . . \textit{Id.} at 651.
ing the institution when such legitimacy is unfounded for the vast majority of mentally retarded citizens. The direct and immediate effect of this may be seen in a failure to develop or fund community programs by diverting legislative appropriations to improve an archaic institutional system whose foundation has melted away.

Criticism of Wyatt's and its progeny's efforts in their formulation and implementation of the right to habilitation is not to diminish the primary thrust and significance of these seminal decisions. Wyatt, in rejecting the custodial care model of the institution and recognizing the developmental potential of mentally retarded citizens, supplied a constitutional basis for habilitation for confined mentally retarded citizens. The right to habilitation, formulated by Wyatt, was designed to remedy the dehumanizing conditions of the institution. In the absence of community programs, the right to habilitation at least supplies a constitutional basis to address the plight of the retarded citizens who remain confined in the asylums of the 19th Century.

NORMALIZATION—EQUAL ACCESS TO HABILITATIVE SERVICES

As community programs continue to develop, the judiciary will be forced to confront the inherently unequal nature of the institutional setting when compared to the community program setting in achieving habilitation. The physical and social integration of mentally retarded citizens with their fellow citizens is a normalization goal which can be achieved by the formulation and implementation of a right to habilitation in the community based upon the Equal Protection Clause. State actions which affect fundamental interests or which establish categories of suspect classifications bring to bear a standard of active review, subjecting such classifications to strict scrutiny. To justify the classification, the state must prove not only that a compelling interest justifies the classification, but that the distinctions drawn are

131. See note 2 supra.
132. See note 28 supra.
necessary to accomplish the state's purpose.\textsuperscript{136} Under strict scrutiny,\textsuperscript{137} the state must demonstrate that there are no reasonable alternative means of accomplishing the stated purpose without discriminating, and that the classification is neither impermissively overbroad nor underinclusive.\textsuperscript{138}

Civil commitment and confinement in an institution abridges a disturbing litany of constitutional guarantees deemed fundamental.\textsuperscript{139} Civil commitment not only drastically restricts the mentally retarded citizen's personal liberty,\textsuperscript{140} but confinement itself circumscribes his freedom of movement or travel both from the institution and within the confines of the institution.\textsuperscript{141} Institutional conditions\textsuperscript{142} flagrantly violate the fundamental rights of privacy,\textsuperscript{143} marriage,\textsuperscript{144} and procreation.\textsuperscript{145} The common institutional practices of the use of seclusion, physical restraints, aversive behavior modification, and excessive reliance upon drugs are so degrading.


\textsuperscript{137} Strict scrutiny is not employed when neither a fundamental interest nor a suspect classification exist. The alternative to the strict scrutiny standard of review requires that the state action be shown to bear some rational relationship to legitimate state purposes. See Levy v. Louisiana, 391 U.S. 68, 71 (1968); McGowan v. Maryland, 366 U.S. 420, 425 (1961).

\textsuperscript{138} See Dunn v. Blumstein, 405 U.S. 330, 343 (1972).


\textsuperscript{140} See note 94 supra.

\textsuperscript{141} The Supreme Court has recognized that the right to travel or freedom of movement is an essential right. Generally, freedom to travel in the context of international travel or interstate travel has been protected by the Court through the Due Process Clause. See Zemel v. Rusk, 381 U.S. 1, 15-16 (1965); Aptheker v. Secretary of State, 378 U.S. 500, 505-06 (1964); Kent v. Dulles, 357 U.S. 116, 125-26 (1958). Clearly, the Court's reasoning is applicable to restrictions upon movement in the institutional setting. In Papachristou v. City of Jacksonville, 405 U.S. 156, 164 (1972), Mr. Justice Douglas emphasized the importance of freedom to merely stroll or walk.


\textsuperscript{143} Although a right to privacy is not explicitly mentioned in the Constitution, the United States Supreme Court has recognized such a right. Roe v. Wade, 410 U.S. 113, 152 (1973); Griswold v. Connecticut, 381 U.S. 479, 481-86 (1965).

\textsuperscript{144} See note 126 supra.

\textsuperscript{145} See note 128 supra.
to the dignity of human beings\textsuperscript{146} as to constitute cruel and unusual punishment.\textsuperscript{147} The "preferred freedoms" of the first amendment\textsuperscript{148} are drastically curtailed if existing at all in the institutional setting.\textsuperscript{149} Institutional "life" is such a day-by-day infringement of fundamental rights for mentally retarded citizens that "liberty" by any definition has no meaning.\textsuperscript{150}

This historical and social experience of mentally retarded citizens, punctuated by a litany of deprivation, meets the three major reasons underlying a "suspect" classification: the unfairness of classifying an individual on the basis of immutable characteristics present at birth;\textsuperscript{151} the protection of politically impotent groups;\textsuperscript{152} and the attaching of a stigma of inferiority.\textsuperscript{153} Mentally retarded citizens, like blacks and the illegitimate, have been con-

\textsuperscript{146} Furman v. Georgia, 408 U.S. 238, 273 (1972) (Brennan, J., concurring opinion).


\textsuperscript{148} The First Amendment speaks unequivocally when it prohibits any law abridging the freedom of speech. Administrative regulations cannot be employed to stifle First Amendment rights. Louisiana v. N.A.A.C.P., 366 U.S. 293 (1961).

\textsuperscript{149} Institutional segregation of residents from society and from the opposite sex within the institution flagrantly violates the most basic premise of the freedom of association: the right to keep company with people of one's choice. See Coates v. City of Cincinnati, 402 U.S. 611, 615 (1971).

\textsuperscript{150} In Doe v. Bolton, 410 U.S. 179 (1973), Justice Douglas, in a concurring opinion, interpreted "liberty" as used in the Fourteenth Amendment to include the following:

First is the autonomous control over the development and expression of one's intellect, interests, tastes and personality.

Second is freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception and the education and upbringing of children.

Third is the freedom to care for one's health and person, freedom from bodily restraint or compulsion, freedom to walk, stroll or loaf.


\textsuperscript{152} Id. at 1125. See also Strauder v. West Virginia, 100 U.S. 303, 306 (1879).

demned to "non-person" status, not by any action on their part, but by birth. Birth conferred upon blacks a skin color, and it conferred upon the illegitimate proof of a liaison beyond the confines of marriage which society has deemed irresponsible. The "political impotence" of mentally retarded citizens is dramatically reflected in society's encouragement and tolerance toward such restrictive measures as: total segregation, compulsory sterilization, institutional peonage, prohibitive marriage provisions, systematic exclusion from public education, and legislative recommendation of euthanasia. To be denied liberty, the opportunity to marry, procreate, be educated, be compensated


The status of illegitimacy has expressed through the ages society's condemnation of irresponsible liaisons beyond the bonds of marriage. But visiting this condemnation on the head of an infant is illogical and unjust. Moreover, imposing disabilities on the illegitimate child is contrary to the basic concept of our system that legal burdens should bear some relationship to individual responsibility or wrongdoing. Obviously, no child is responsible for his birth and penalizing the illegitimate child is unjust. Courts are powerless to prevent the social opprobrium suffered by these hapless children, but the Equal Protection Clause does enable us to strike down discriminatory laws relating to status of birth where the classification is justified by no legitimate state interest, compelling or otherwise.

Id. at 175-76.


156. The dehumanizing practice of compulsory sterilization resulted from judicial acquiescence to the myth that until sterilization is effected, a mentally retarded citizen is a defective person who is a detriment and menace to society. Buck v. Bell, 274 U.S. 200, 205-06 (1927).


158. See note 21 supra.


for their work, even life, is a haunting indictment of political powerlessness suffered by this "insular minority." 161 Clearly, a stigma of inferiority, the central rationale upon which the Supreme Court has justified the determination of a classification as suspect, 162 has been thrust upon mentally retarded citizens. The label "retarded" has historically evoked this judgment of inferiority founded upon the destructive perceptions of mentally retarded citizens as "subhumans," "defects," or "menaces." 163

Notwithstanding these historical and social realities, any arguments suggesting that mental retardation is a constitutionally suspect classification must confront the dictum of Mr. Justice Brennan in Frontiero v. Richardson. 164 Mr. Justice Brennan, writing for four members of the Court who would have held sex a suspect criteria, suggested:

[W]hat distinguishes sex from such nonsuspect statuses as intelligence or physical disability and aligns it with the recognized suspect criteria, is that the sex characteristic frequently bears no relation to ability to perform or contribute to society. 165

Mr. Justice Brennan's dictum suggests that classification based upon intelligence, such as mental retardation, often relates to personal limitations which might well serve as a legitimate basis for state regulation.

Mr. Justice Brennan's classification does not withstand analysis. First, it is the mental retardation classification that frequently bears no relation to the ability of mentally retarded citizens to perform or to contribute to society. 166 Of the estimated six million

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161. The "insular minority" basis for determining suspect classification was first suggested by Mr. Justice Stone in United States v. Carolene Products Co., 304 U.S. 144 (1938):

[P]rejudice against discrete and insular minorities may be a special condition, which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for correspondingly more searching judicial inquiry.

Id. at 153 n.4.


165. Id. at 686.

mentally retarded citizens, over five million (approximately 89 percent) with proper education and training by adulthood, can live and work independently.\textsuperscript{167}

Second, the classification of mental retardation bearing upon the mentally retarded citizen's merit or performance, as suggested by Mr. Justice Brennan, is representative of the stereotyped "self-fulfilling prophecy." Predictions made about mentally retarded citizens come true because the environment constructed for them in institutions allows no other behavior to develop except that which has been predicted.\textsuperscript{168} Furthermore, the specific abuses inflicted upon mentally retarded citizens trigger the majoritarian abuse and stigma rationales.\textsuperscript{169}

Finally, the recent declaration by Mr. Justice Powell as to the traditional indicia of suspectness would indicate that the classification "mentally retarded" is suspect. Mr. Justice Powell stated that a system of alleged discrimination and the class it defines are suspect where the class is saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.\textsuperscript{170}

However, should courts decline to find the classification of mental retardation a suspect classification for all purposes, the utilization of the classification of mental retardation for confinement in segregated and isolated institutions should still require strict judicial scrutiny.\textsuperscript{171} The interface of civil commitment's infringement upon fundamental interests and the particularly vulnerable position mentally retarded citizens occupy in society should trigger a strict scrutiny of the legislative choice of confining mentally retarded citizens to isolated segregated institutions for habilitation.

Recent decisions of the Supreme Court have indicated a willingness to assess legislative means in terms of legislative purposes that have a substantial basis in fact, not merely conjecture.\textsuperscript{172}

\textsuperscript{167} R. Conley, The Economics of Mental Retardation 6-49 (1973).
\textsuperscript{168} See note 29 supra.
\textsuperscript{169} See text at notes 152-153 supra.
\textsuperscript{171} See R. Burt, Beyond the Right to Habilitation, in The Mentally Retarded Citizen and the Law 418 (President's Committee on Mental Retardation, 1976).
\textsuperscript{172} See, e.g., Weber v. Aetna Casualty & Surety Co., 406 U.S. 164, 172 (1972); Reed v. Reed, 404 U.S. 71, 75-76 (1971). See also note 95 supra.
Under this analysis, a heightened judicial scrutiny of the state's choice would necessitate an examination of the alternatives to establish that the state's choice bears a fair and substantial factual relation to the object of the legislation.\textsuperscript{173}

**HORACEK v. EXON—NORMALIZATION IMPLEMENTED**

The existence of alternatives such as the community programs in Nebraska indicates that continued reliance upon confinement of mentally retarded citizens for habilitation in an institution lacks a compelling state interest justifying the confinement, that reasonable alternatives exist to accomplish the purpose, and that confinement lacks a fair and substantial factual relation to the purpose. The very existence of a successful alternative to the institution and the disparity in conditions and practices between such alternatives and the institution in Nebraska\textsuperscript{174} precipitated five residents of the state institution to file a right to habilitation suit\textsuperscript{175} modeled after *Wyatt v. Stickney*.\textsuperscript{176}

The complaint in *Horacek* differed critically in one aspect from the *Wyatt* effort. *Horacek* alleged that the State of Nebraska was operating a dual system of treatment in violation of the Due Process Clause and Equal Protection Clause of the fourteenth amendment in that mentally retarded citizens in Nebraska of similar disabilities were being habilitated in a system of community services far less restrictive of personal liberties and substantially superior as to the level of habilitation.\textsuperscript{177} Thus the thrust of the *Horacek* complaint was the continued legitimacy of the institution, which *Wyatt* and *Welsch* failed to address.

The factual foundation for the *Horacek* allegation, aimed at dismantling the institution, rested upon the opinion of leading experts in the field of mental retardation and data accumulated by the community programs since their inception in 1969, indicating that community programs were not only habilitating mentally retarded citizens in an integrated normalizing setting but in a manner


\textsuperscript{174} For reports critical of conditions present at Nebraska's institution, the Beatrice State Home, see *The Report of the Nebraska Citizen's Study Committee on Mental Retardation* (1968); *The Report of the Human and Legal Rights Committee of the Nebraska Association for Retarded Children* (1972).

\textsuperscript{175} Horacek v. Exon, 357 F. Supp. 71 (D. Neb. 1973) (Memorandum and Order on Motion to Dismiss); Civil No. 72-L-299 (D. Neb., consent decree entered Oct. 31, 1975).

\textsuperscript{176} See note 73 supra.

\textsuperscript{177} 357 F. Supp. at 72.
far less restrictive of constitutional rights. Utilizing these facts the plaintiffs and plaintiff-intervenor\textsuperscript{178} in \textit{Horacek} sought to establish that the community programs with their proven success were the less drastic, reasonable alternative to accomplish habilitation and that continued reliance upon the institution for habilitation by the state was neither "compelled" nor justified.

On October 31, 1975, the Federal District Court of Nebraska entered a consent decree in \textit{Horacek}, approving and incorporating a settlement agreement entered into by the parties on August 6, 1975. The consent decree in \textit{Horacek}, recognizing a constitutional right to habilitation in the least restrictive alternative and the civil and constitutional rights of mentally retarded citizens, approved the reduction of the institutional population from 1200 to a "goal" of 250 within three years.\textsuperscript{179}

Reflecting the concern of all parties that the reduction would be an orderly transfer and not a "dumping" of mentally retarded citizens into the community, the \textit{Horacek} decree further provided a detailed assessment mechanism to insure appropriate placement.\textsuperscript{180} The \textit{Horacek} decree, by providing a mechanism for the orderly placement of mentally retarded citizens into community programs, not only reflects the primary tenet of normalization—access to habilitative services in an integrated setting—the decree mandated its implementation to the fullest extent.

Thus, \textit{Horacek} may be viewed as an extension of the right to habilitation in an institutional setting formulated by \textit{Wyatt} to the right to habilitative services within the community. Such an extension denotes a distinct shift from judicial intervention aimed at

\textsuperscript{178} The United States of America on March 10, 1975 had made application to intervene as a party plaintiff. The district court granted the application on March 28, 1975. Earlier, the court had allowed the National Center for Law and the Handicapped to intervene as amicus curiae.

\textsuperscript{179} The settlement agreement also imposes upon the institution the Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals (current) and the staff ratios contained in \textit{Wyatt v. Stickney}, 344 F. Supp. 387 (M.D. Ala. 1972) and \textit{New York State Ass'n for Retarded Children v. Carey}, Civil Nos. 72-356, 72-357 (E.D.N.Y., consent decree entered on May 2, 1975).

\textsuperscript{180} The settlement agreement, embodied in the consent decree, requires the Governor: to prepare a statewide plan to address the population reduction goal and the time frame necessary to achieve the goal; identify the method by which the reduction is to be achieved; establish teams to evaluate each mentally retarded person in the institution and prepare individualized evaluations, treatment plans and placement recommendations; and insure that current services are not curtailed to meet the requirements of the agreement. \textit{Horacek v. Exon}, Civil No. 72-L-299 (D. Neb., consent decree entered October 31, 1975).