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HUMAN RIGHTS AND MENTAL DISABILITY: PERSPECTIVES ON ISRAEL

*Stanley S. Herr**

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I. *Introduction*

The human rights of persons with mental disabilities represents a frontier area for legal protection. The content and means of enforcing their rights have become topics of both scholarly and popular concern. For two decades, the international community has grappled — somewhat fitfully — with the human rights norms that should guide nations in their care and treatment of these vulnerable groups. International concern has focused not only on problems of arbitrary detention and cruel, inhumane or degrading treatment, but on issues of institutionalization, sterilization, and a broad array of education, treatment and welfare services.

In many countries, obsolete legislation and service delivery models have hindered the realization of both negative and affirmative (“positive resource claims”) human rights.¹ As devalued and marginalized citi-

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1 See L. Henkin, *The Age of Rights* (1990) 2; P. Morris, *Put Away: A Sociological Study of Institutions for the Mentally Retarded* (1969).

zens, persons with mental disabilities have historically had difficulties in convincing their fellow citizens of their personhood, let alone of their citizenship and possession of enforceable rights.² As a result, the law has often sanctioned their inferior status and exclusion from society.³

In recent years, persons regarded as mentally disabled have turned to the courts, legislators, executive officials, and other legal institutions to undo those harms. Disability-rights movements have begun to demand policies of inclusion, integration, and equal rights. These movements in the United States and Western Europe have struggled not only for liberty rights but for the establishment and improvement of vital social, educational, and rehabilitative services.⁴ Israel, too, has witnessed the stirrings of a human rights campaign for greater independence and community living for persons with mental disabilities.⁵ In response to these developments, reviews of legislation and practices affecting the human rights of disabled persons in general, and mentally disabled persons in particular, are now underway.⁶ While theoretically entitled to the existing legal and human rights safeguards available to all persons, persons with mental disabilities may possess characteristics or be the subject of such severe prejudices and discrimination as to require distinctive rights and safeguards. When coupled with an infu-

- 2 A. Soifer, "On Being Overly Discrete and Insular: Involuntary Groups and the Anglo-American Judicial Tradition", (1990) 20 *Is. Yrbk. Human Rights* 243, at 248, 256 (noting the appalling precedents and lack of judicial solicitude that mentally retarded citizens and other minority groups have experienced).
- 3 See M. Minow, *Making All the Difference: Inclusion, Exclusion, and American Law* (1990) 116, 127-35; M. Minow, "When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference", (1987) 22 *Harv. C.R.-C.L. L. R.* 111.
- 4 R. Scotch, "Politics and Policy in the History of the Disability Rights Movement", (1989) 67 *Milbank Q.* 380 (Suppl. 2, pt. 1).
- 5 See, e.g., Jerusalem Parents Lobby on Community Living for the Developmentally Disabled, *Community Living for People with Developmental Disabilities in Jerusalem in the 1990s*: Position Paper Presented to the Deputy Minister for Labour and Social Affairs, the Mayor of Jerusalem and the Public (December 1990, in Hebrew); C. Aharoni, *Not Exactly As Everybody: Forty Years Struggle for Our Impaired Children* (1989, in Hebrew) 109-12 (criticisms that Israel lags far behind the U.S., Canada and the Scandinavian countries in community services and legal protection for persons with mental retardation).
- 6 E.g., U.N. Secretary-General on the Implementation of the World Programme of Action, A/41/605 of 23 September 1986, para. 36-40; Minutes of Shnit Committee on Revision of Mental Retardation Law, appointed by the Ministry of Labour and Social Affairs [hereinafter: Shnit Committee].

sion of fiscal and professional resources, such legal protection can help these persons overcome obstacles to their enjoyment of human rights, including access to "equality of opportunity and treatment, to social participation and to independent living".⁷

This article focuses on the legal protection afforded Israelis with special needs, particularly those labeled as mentally retarded or mentally ill, with some comparisons to the United States. These countries present contrasts between a highly legalized, frequently adversarial system of disability care and a more informally structured system in which negotiation predominates. A distinctive Israeli cultural and political background to the legal problems of disabled persons exists due to a supportive and caring environment for such persons through a national commitment to absorb new immigrants regardless of their disabilities and limitations.⁸ Although there is a constituency in each country for human rights and equal treatment of disabled persons, the advocacy methods employed and the legal protection provided are markedly different in Israel and the United States.⁹

Despite obvious differences in size, age, wealth and the delineation of constitutional rights,¹⁰ the two countries share many common fea-

7 UN Economic and Social Council, Commission on Human Rights, *Human Rights and Disability* (progress report prepared by Mr. Leandro Despouy, special rapporteur, E/CN.4/sub.2/1988/11, 13 June 1988).

8 See Y. Shachar, "Culture, Insanity and the Right to Be Wrong", (1985) 15 Is. Yrbk. Human Rights 204. New immigrants to Israel from the Soviet Union and Ethiopia include a significant number affected by mental retardation, physical disability, or old age who will require intensive social services. *Jerusalem Post*, p. 2, 1 July 1991. In contrast, North American immigration law is highly exclusionary in its treatment of the mentally retarded, the mentally ill, and other stigmatized groups. 8 U.S.C. § 1182(a) (1988) (listing aliens who are mentally retarded, insane, or "afflicted with . . . a mental defect" among the twenty-eight categories of persons excluded from admission into the U.S.). See also R. Green, "Give Me Your Tired, Your Poor, Your Huddled Masses, Except Homosexuals: An Analysis of American and Canadian Immigration Policy", (1987) 16 Anglo-American L. R. 139. Recent amendments to U.S. immigration law narrow the classes of excludable disabled aliens to persons whose disability poses a threat to "the property, safety, or welfare of the alien or others". 8 U.S.C. § 1181(a)(1)(A)(ii) (Supp. II 1990).

9 On the lesser degree of advocacy and citizen participation in the disability field in Israel, as compared to the U.S., see R. Kramer, *Voluntary Agencies in the Welfare State* (1981).

10 See, e.g., R. Gavison, "The Controversy over Israel's Bill of Rights", (1985) 15 Is. Yrbk. Human Rights 113.

tures of the modern welfare state. These features include legal responsibilities to provide a wide range of services to disabled citizens, complex bureaucracies, and an independent judiciary and legal profession sensitive to human rights concerns.¹¹ Both countries proclaim that they are welfare states, states whose hallmarks are that all citizens enjoy government-protected, minimum standards of education, health, housing, income, and nutrition as "a political right, not as charity".¹²

This article is divided into three main parts. Section II will examine certain international human rights standards that can serve as measures of achievement for domestic laws in the disabilities field. Section III will analyze recent developments pertaining to the right to appropriate special education, access to residential and other developmental services, sterilization, civil commitment of psychiatric patients, and other individual rights. It will attempt to make some assessments of this Israeli experience from international and American perspectives. Section IV will then explore factors that affect Israel's protection of the human rights of persons with mental disabilities, and offer some suggestions for reform and structural change. The conclusion will summarize some of the tasks ahead.

II. *International Standards*

Human rights are often described as universal rights. Such rights may be defined as "those moral-political claims that, by contemporary

- 11 See generally S. Shetreet, "International Protection of Human Rights in Israeli Law", in *Israeli Reports to the XIIth International Congress of Comparative Law*, S. Goldstein, ed., (Jerusalem, 1986) 307; R. Cnaan, "The Evolution of Israel's Welfare State", in *Modern Welfare States: A Comparative View of Trends and Prospects*, R. Friedmann, N. Gilbert & M. Sherer, eds. (1987) 174, at 183 ("Human rights, citizen participation and consumer rights, including those of welfare clients, have become issues of great importance in Israel in the last decade".).
- 12 See H. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (1975) 1. For example, Justice Haim H. Cohn has described Israel as a modern welfare state that has undertaken the "legal responsibility of providing all citizens with all the services, facilities and amenities ... to ensure a proper standard of living for all . . .". H. Cohn, "Comparative Law and International Protection of Human Rights", in *Israeli Reports to the XIth International Congress of Comparative Law*, S. Goldstein, ed., (Jerusalem, 1982) 263, at 267. See J. Lehman, "To Conceptualize, To Criticize, To Defend, To Improve: Understanding America's Welfare State", (1991) 101 *Yale L.J.* 685.

consensus, every human being has — or is deemed to have, or should have — upon his or her society and government”.¹³ It may well be asked whether that consensus has yet crystallized for persons with mental retardation or mental illness. How are universal rights to be understood when applied to segments of the population who are defined by characteristics which tend to focus on their limitations? Proponents of human rights assert that “there is now a working consensus that every man and woman, between birth and death, counts, and has a claim to an irreducible core of integrity and dignity”.¹⁴ But what exactly is that core and should it be expressed in different ways to take into account the greater needs for social welfare and social rights of the chronically mentally ill or the severely mentally retarded?¹⁵ Persons with mental disabilities or persons regarded as disabled too often face threats of oppression and unjustified loss of liberty, but they have equally pressing claims to protection from poverty and neglect.¹⁶ By identifying those claims as human rights, the legal system can recognize a set of universal norms for a class of persons subject to special vulnerabilities, promote standards for their domestic legal protection, and apply those standards with rigour and consistency.¹⁷

The international community has begun that enterprise at both the non-governmental organization (NGO) and United Nations (UN) levels. To date, the primary vehicle for this activity has been declaration-

13 L. Henkin, *supra* n. 1, at 143.

14 *Ibid.*, at 193.

15 For the argument that the rights of persons with mental disabilities should depend on their capacity to use them and their reciprocal responsibilities to society, see D. Feldman, “Rights, Capacity and Social Responsibility”, (1987) 16 *Anglo-American L. R.* 97, at 114. (“The old fashioned view that a handicapped person was so different from other people as to be incapable of having any rights at all was pernicious and is now, happily, on the retreat, but a more recent idea, that all handicapped people have all the same rights as everyone else, is without support from any sustainable theory of the conditions under which entities can be said to ‘have’ rights”).

16 L. Henkin, *supra* n. 1, at 179. See, e.g., World Federation for Mental Health, Declaration of Human Rights and Mental Health (26 August 1989) (Art. 4 proclaims, *inter alia*, the rights to “coercion-free, dignified, humane and qualified treatment”, to “protection from physical or psychological abuse”, and to “protection from professional or nonprofessional neglect and abandonment”).

17 See E. Gordon, “The Elderly and the International Legal Process”, in *Law and Aging: International Variations*, M. Levine & S. Bergman, eds., (1988) 17; A. Eide, “Realization of Social and Economic Rights and the Minimum Threshold Approach”, (1989) 10 *Human Rights L. J.* 35.

making.¹⁸ The pioneering Jerusalem Declaration on the General and Special Rights of Mentally Retarded Persons was promulgated by the International League of Societies for the Mentally Handicapped (ILSMH) in 1968.¹⁹ This NGO declaration then served as the inspiration and model for two UN human rights declarations concerning disabilities.

In 1971, the UN Declaration on the Rights of Mentally Retarded Persons, in terms nearly identical to the ILSMH text, was adopted by the General Assembly without a single negative vote.²⁰ In seven concise articles, it proclaims that the mentally retarded person has "the same rights as other human beings", as well as rights to developmental services, "a decent standard of living", normal modes of life, protective services, legal protection from "abuse and degrading treatment", and "proper legal safeguards" when any rights are restricted because of incapacity.

Four years later, the UN Declaration on the Rights of Disabled Persons called for international and national action to protect the rights of all physically and mentally disabled persons.²¹ Both the functional definition of the disabled person and the enumeration of their rights are sweeping and categorical.²² These rights are granted regardless of the degree, origin or type of disability. With principles of egalitarianism and normalization given primacy, the 1975 Declaration states that disabled persons have "the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a

- 18 On the declaration as the "dawn of the law" and its influence on positive domestic law, see Lador-Lederer, "Promotion of Health — The Making of an International Norm", (1988) 18 *Is. Yrbk. Human Rights* 121, at 152.
- 19 Adopted at the Fourth International Congress of ILSMH, 24 October 1968, Jerusalem, reprinted in ILSMH, *From Charity to Rights* (1969) 160-61. For a comparable NGO declaration in the field of mental health, see World Federation for Mental Health, Declaration of Human Rights and Mental Health (26 August 1989). This Declaration is notable for its emphasis on the promotion of "the greatest degree of self-determination" on the part of mentally ill persons and the provision of treatment in "settings valued and accepted by the community, in the least intrusive manner, and under the least restrictive circumstances possible". *Ibid.*, Art. 5.
- 20 G.A. Res. 2856, 26 U.N. GAOR, Supp. No. 29 at 99, U.N. Doc. A/8429 (1971).
- 21 G.A. Res. 3447, 30 U.N. GAOR, Supp. No. 34 at 92, U.N. Doc. A/10034 (1975).
- 22 Disabled person is defined as "any person unable to ensure by himself or herself wholly or partly the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities". *Ibid.*, Art. 1.

decent life, as normal and full as possible".²³ Other equality provisions set out rights to nondiscrimination, equal civil and political rights, and the broadly stated "inherent right to respect for their human dignity".²⁴

The Declaration's affirmative social and economic rights are notable for their breadth. Rights to treatment, rehabilitation, education, vocational education, training, counseling, aid, placement services, economic security, social security, family living, and participation in recreational and cultural activities are some of the measures enumerated to develop "capabilities and skills to the maximum" and to speed "social integration or reintegration".²⁵

The 1975 Declaration also contains prohibitions against "all exploitation"; discriminatory, abusive or degrading treatment and regulations; unnecessary "differential treatment" in residence; and requires living conditions in specialized facilities that are as "close as possible to those of normal life of a person of his or her own age".²⁶ Other provisions delineate entitlements of disabled persons that will "enable them to become as self-reliant as possible", and to have their "special needs taken into consideration at all stages of economic and social planning".²⁷ In emphasizing the need for redress and awareness of rights, the Declaration requires "qualified legal aid when such aid proves indispensable" for their personal or property protection, and full information to disabled persons and their families on these declared rights.²⁸ It also urges governments to consult with organizations of disabled persons on all matters regarding their rights.²⁹ While this set of standards is

23 *Ibid.*, Art. 3.

24 *Ibid.*, Arts. 2, 3, & 4. On recognition of human dignity under the Universal Declaration of Human Rights, and its concrete applications to the individual's liberty, equality and physical integrity, see D. Shraga, "Human Rights in Emergency Situations under the European Convention on Human Rights", (1986) 16 *Is. Yrbk. Human Rights* 217, at 231-32.

25 G.A. Res., 3447, 30 U.N. GAOR, Supp. No. 34, at 92, U.N. Doc. A/10034 (1975), Arts. 6, 7, & 9.

26 *Ibid.*, Arts. 10 & 11.

27 *Ibid.*, Arts. 5 & 7.

28 *Ibid.*, Arts. 11 & 13.

29 *Ibid.*, Art. 12.

impressive, clearly a declaration per se is insufficient for the beneficiaries to realize this litany of rights.³⁰

The UN Convention on the Rights of the Child provides a firmer legal foundation for the rights of minors with disabilities.³¹ Article 23, for instance, specifies the rights of mentally and physically disabled children to a wide spectrum of rehabilitation services and special care. First, the article recognizes that such children “should enjoy a full and decent life”, with conditions promoting dignity, self-reliance, and “active participation in the community”.³² Second, ratifying nations recognize, with various caveats, the child’s right to special care appropriate to the individual’s condition and the parental or other caregivers’ circumstances.³³ Third, in recognition of the disabled child’s “special needs”, this care and assistance “shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recre-

30 The international community can also promulgate narrower, but more detailed human rights standards. For example, the UN Commission on Human Rights is considering the adoption of minimum UN standards for the protection of mental patients. In March 1989 the Commission established a working group to draft “Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care”. That text has now been submitted with the hope that the UN General Assembly will eventually adopt it as a guide for “the protection of fundamental freedoms and human and legal rights of persons with mental illness”. UN Economic and Social Council, Commission on Human Rights, *Human Rights and Scientific and Technological Developments: Report of the Working Group on the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, Annex II at 20, E/CN.4/1991/39, 5 February 1991.

These 21 principles are notable for their commitment to community living (“every person with a mental illness shall have the right to live and work, as far as possible, in the community”, *id.* at 9), treatment in the least restrictive environment, the right to judicial appeal and other procedural safeguards in the admissions and retention process, and the development of remedial mechanisms to foster rights compliance and to secure “appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of patients”. *Id.* at 18. To implement these principles, states would be urged to take various legislative, judicial, administrative, educational and other measures.

31 *Opened for signature*, 26 January 1990, & *entered into force*, 2 September 1990, (1989) 28 I.L.M. 1448, at 1456. Child is defined as “every human being below the age of eighteen years”. Convention on the Rights of the Child, Art. 1.

32 *Ibid.*, Art. 23(1).

33 *Ibid.*, Art. 23(2). For discussion of some of those caveats and limitations, see text and notes at nn. 47-49, *infra*.

ation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development"³⁴ Under other relevant articles, States Parties recognize the child's right to periodic review of treatment when placed for purposes of care or treatment of physical or mental problems,³⁵ right to education,³⁶ right to health and treatment facilities,³⁷ and right to the nondiscriminatory enjoyment of declared rights irrespective of the child's disability or other ascribed status.³⁸

The Convention calls for strong protection for the institutionalized child. States Parties shall ensure that such a child receives services meeting established standards of health, safety, supervision and staffing,³⁹ as well as protection and care to ensure their well-being,⁴⁰ and protective measures against all forms of abuse and maltreatment.⁴¹ Like the UN Declaration on the Rights of Disabled Persons, the Convention reflects a strong presumption against out-of-home institutional treatment and a preference for "a family environment" when residential treatment is required.⁴² Furthermore, a decision to place a child away from parents against their will must be subject to judicial review.⁴³

In strikingly emphatic terms, the child is accorded a right to privacy and family integrity and the protection of the law against interference with these rights. According to Article 16, "[n]o child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation".⁴⁴ Although this absolute right applies to any child,

34 *Ibid.*, Art. 23(3). A final paragraph calls upon States Parties to exchange information on methods of treating, rehabilitating, and otherwise assisting disabled children.

35 *Ibid.*, Art. 25.

36 *Ibid.*, Art. 28.

37 *Ibid.*, Art. 24.

38 *Ibid.*, Art. 2.

39 *Ibid.*, Art. 3(3).

40 *Ibid.*, Art. 3(2).

41 *Ibid.*, Art. 19.

42 See *ibid.*, Preamble, Art. 18(1), & Art. 20(3). G. Melton, "Promoting the Dignity of the Child Through Mental Health Services", in *Children's Rights in America: U.N. Convention on the Rights of the Child Compared with United States Law*, C. Cohen & H. Davidson eds. (1990) 239, at 247.

43 Convention on the Rights of the Child, Art. 9(1).

44 *Ibid.*, Art. 16(1). On the uniqueness of this provision and its support for the child's right to individual dignity, see C. Cohen, "A Guide to Linguistic Interpretation of the Convention on the Rights of the Child", in *Children's Rights in America*, *supra* n. 42, at 36.

institutionalized children should especially benefit, since they face unusual risks of unwarranted stigma, lack of privacy, and interference with their homes, family lives, and communications.

It is too early to assess this Convention's impact. While the Convention was entered into force on September 2, 1990, Israel only recently ratified it and the United States has yet to ratify it.⁴⁵ Furthermore, parties to this human rights treaty have two years from its ratification to report on the measures undertaken to give these rights effect and on "progress made on the enjoyment of those rights".⁴⁶ A UN committee on the rights of the child, composed of ten internationally recognized experts, will receive these reports, assess progress, and interpret the Convention's provisions. In carrying out these tasks, the committee must take into account the various limitations contained in the document itself. This includes the principle of progressive implementation of economic, cultural and social rights, such as the rights to disability services, health, and education.⁴⁷ Another obstacle to forceful implementation is vaguely worded limitations on the child's right to freedom of thought, conscience and religion.⁴⁸ In addition, the committee will have to interpret ambiguously worded provisions that reflect the compromises and gaps resulting from a negotiation process conducted over a ten-year period.⁴⁹

Despite such difficulties, the Convention can serve as a guidepost and tool for assessing human rights compliance. Embodying a moral and legal consensus as to the minimum rights of children with disabilities,

45 While the U.S. has neither signed nor ratified the Convention, Israel signed it and deposited the instrument of ratification with the U.N. Secretary General on 3 October 1991. Letter from Avraham Lavine, Director of the Department of International Relations, Ministry of Labour and Social Affairs, to Stanley S. Herr (10 November 1991).

46 Convention on the Rights of the Child, Art. 44(1).

47 *Ibid.*, Arts. 4, 23(4), 24(4), & 28(4).

48 *Ibid.*, Art. 14(1). E.g., "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others". *Ibid.*, Art. 14(3).

49 E.g., "States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, *subject to available resources*, to the *eligible child* and those responsible for his or her care, *of assistance for which application is made* and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child". *Ibid.*, Art. 23(2) (emphasis added).

it can spur nations to study and upgrade the protection afforded all children.

III. *Recent Developments in Israel*

A. *Context*

An extensive body of literature exists on the protection of human rights in Israel in general.⁵⁰ Such accounts tend to emphasize civil and political rights, and the role of judicial vigilance in defending human rights in a "young democracy which is besieged and in an . . . endless state of national emergency".⁵¹ Interest in individual rights may also be dampened by an Israeli ideology of nation building and Jewish law's focus on concepts of duty rather than human rights.⁵² As a result, the field of human rights of persons with disabilities, let alone mental disabilities, has received only limited attention to date. A few scholars have explored the liberty-related rights of psychiatric patients,⁵³ and the elderly infirm.⁵⁴ Other rights of mentally disabled persons, particularly persons with mental retardation and other developmental disabilities, are for the most part *terra incognita*.⁵⁵ The discussion below examines some recent developments in the protection of the rights of persons with

50 See, e.g., B. Bracha, "The Protection of Human Rights in Israel", (1982) 12 Is. Yrbk. Human Rights 110; A. Shapira, "The Status of Fundamental Human Rights in the Absence of a Written Constitution", (1974) 9 Is. L. R. 497.

51 B. Bracha, *supra* n. 50, at 126.

52 P. Lahav, "Foundations of Rights Jurisprudence in Israel: Chief Justice Agranat's Legacy", (1990) 24 Is. L. R. 211, at 221-22, citing H. Cohn, *Human Rights in Jewish Law* (1984) 17-20. Jewish law governs many matters of personal status in Israel, and such law tends to view persons with mental disabilities as outside the framework of obligations.

53 U. Aviram & D. Shnit, "Involuntary Psychiatric Hospitalization and Civil Liberties — The Case of Israel", in *Psychiatry, Law and Ethics*, A. Carmi, S. Schneider & A. Hefez, eds. (1986) 106; U. Aviram & D. Shnit, "Psychiatric Treatment and Civil Liberties in Israel: The Need for Reform", (1984) 21 Is. J. Psychiatry & Related Sciences 3.

54 D. Shnit, "Protection in Israel of the Property Interests of the Elderly with Impaired Capacity to Function", (1987) 17 Is. Yrbk. Human Rights 222.

55 For an exception, see D. Shnit, *The Law, the Individual and the Social Services: The Legal Basis for Social Work in Israel* (1988, in Hebrew) 278-324 (on mental retardation), 325-374 (on mental illness).

mental disabilities and the adequacy of existing law in light of evolving standards and professional principles.

B. *Rights to Special Education*

Access to special education remains problematical for children with disabilities. In the early years of the state, the Knesset attempted to ensure the educational rights of children generally.⁵⁶ The statutes, however, lacked detail as to the modes of securing appropriate education for all children with mental or physical handicaps, and permitted the exemption of many children from compulsory education or their inappropriate placement.⁵⁷ The Special Education Law of 1988 [hereinafter: S.E.L.]⁵⁸ was intended to remedy those deficiencies, but its implementation to date has been limited to a demonstration project in only two municipalities.

The S.E.L. mandates free, appropriate education in the least restrictive environment for children in need of special education. With the state undertaking the responsibility of providing special education free of charge, each "maladjusted child" is legally entitled to such education in his or her area of residence, or as near as possible if suitable programs are not available through the local education authority.⁵⁹

The law broadly defines the eligible children (aged 3 to 21) and the special education and subsidiary services to meet their needs.⁶⁰ Thus,

56 Compulsory Education Law, 1949, 3 L.S.I. 125; State Education Law, 1953, 7 L.S.I. 113.

57 Compulsory Education Law, secs. 4A-4E, & 9, repealed by Special Education Law, *infra* n. 58, sec. 21.

58 [1988] S.H. 1256, p. 114.

59 *Ibid.*, secs. 3 and 4(a). Although the terminology, "maladjusted child", is somewhat pejorative and may imply wilful misbehaviour, the class of children covered broadly corresponds to a child with a disability as defined under U.S. law. Cf. Individuals with Disabilities Education Act, Pub. L. No. 101-476, Oct. 30, 1990, 104 Stat. 1141, 20 U.S.C.A. § 1401(a)(1) (West Supp. 1991). This law was previously named the Education for All Handicapped Children Act of 1975. See *infra* n. 83.

60 S.E.L., sec. 1. "Maladjusted child" means a person of any age from three to twenty-one years whose capacity for adjusted behaviour is limited owing to defective development of his physical, intellectual, or behavioural faculties and who is in need of special education; . . ." A 1989 amendment to this law made the obligation to educate children aged 3-4 and over 18 effective from September 1991 with phased-in implementation to be completed by 1998. Amended, sec. 24(a).

the child is to receive "systematic instruction, teaching and treatment" suited to his or her needs, including treatments such as physiotherapy, speech therapy, and occupational therapy as well as subsidiary services such as transportation, medical, paramedical, psychological and social services.⁶¹ The legislatively declared purpose of special education is to develop the child's abilities and skills in order to engage in normalized behaviour and become integrated in society and the "employment cycle".⁶²

Under the evaluation and placement process specified by the law, each child's case is reviewed by a multi-disciplinary placement committee. The committee determines the special education services required by the child. In making this determination, it must give priority to placement in regular education with special treatment when appropriate. Parental participation is encouraged by the law since the committee is obligated to summon the parents and to hear them or their representative.⁶³ If dissatisfied with the committee's decision, the parents, the child or a "public organization" may appeal to an objection committee. That committee is empowered to change the decision of the placement committee, or dismiss the appeal.⁶⁴

The letter of the law however, bears little resemblance to the law in practice. Unfortunately, the S.E.L. has so far had relatively little practical impact due to funding and other implementation obstacles. The law was introduced as a private member's bill, and the Ministry of Education has appeared reluctant to put the basic entitlement into national effect.⁶⁵ The law embodied a compromise permitting a 7-year phased implementation of the requirements for special education for children aged below 5 or above 18 and the provision of subsidiary services.⁶⁶ All other parts of the law were to come into force by January 1989, six

61 S.E.L., sec. 1.

62 *Ibid.*, sec. 2.

63 *Ibid.*, sec. 9(b). The authorized English translation of this law appears to have erroneously rendered this mandatory duty in the following terms: "(b) The committee *may* summon the parents of the maladjusted child and enable them or someone on their behalf to be heard". (emphasis added). The committee may also hear the child.

64 *Ibid.*, sec. 13(b).

65 This development not only reflects financial problems, but philosophical differences on the merits of amending the general education laws instead of adding a separate legal framework for special education. Interview with Dr. Arik Rimmerman, Senior Lecturer, Bar-Ilan University (27 July 1991).

66 S.E.L., sec. 24(a)(1)-(2).

months after the law's date of publication.⁶⁷ However, the Ministry of Finance succeeded in having the entire law postponed by a year when a one-sentence amendment was buried in an unrelated finance law and, without notification to the advocacy community, was passed by the Knesset with no debate.⁶⁸ After pressure from an advocacy coalition, the Ministry of Finance subsequently approved a modest appropriation to conduct a demonstration project at two "experimental sites" in Jerusalem and Rishon LeZion.⁶⁹ Yet even within this narrow scope, the law is not being fully implemented. Both parents and advocates report that some children are receiving only half-school days of special instruction, parents are often discouraged by teachers from appearing at placement committee meetings, and such committees do not give priority to special instruction in regular education as the law requires.⁷⁰ As a result, the law has been drained of much of its meaning by limited funds, lack of teacher retraining, lack of the full array of special education services, lack of comprehensive plans for implementing the law, and delay tactics. Labeling the initial implementation as "a demonstration project" politi-

68 Interview with Yitzhak Kadman, Director, National Council for the Child, Jerusalem (10 January 1991). See S.E.L. Amendment of 1990.

69 The appropriation was four million shekels (NIS) (less than two million U.S. dollars). The S.E.L. 1990 amendment authorizes the Minister of Education to set the budget for special education and to limit the number of persons served each year in such programs. *Ibid.*, sec. 7(a).

70 Interview with Noga Yaffe, Chairperson, "YATED" (Association for Children with Downs' Syndrome), Jerusalem (30 May 1991). The Association for Civil Rights in Israel (ACRI) has engaged in advocacy for children denied appropriate special education. One proposed case of a retarded boy, allegedly excluded from education, was resolved after he was finally placed in a residential home with a school program. In 1992, ACRI filed two court petitions under the S.E.L. to secure the rights of children with disabilities. In *Mazaltrim v. Minister of Education* (H.C. 1100/92) the S.E.L. placement committee decided that a pupil with severe cerebral palsy should be placed in a regular class with supplemental services of physical therapy, occupational therapy and tutoring. When this decision was not implemented and the child was instead placed in a school for children with mental retardation, ACRI argued, *inter alia*, that the Minister of Education had failed in his duty to issue a plan for the S.E.L.'s seven-year implementation. *Gur-Ziv v. Minister of Education* (H.C. 3023/92) raises a similar issue of the failure to provide integrated education for children who can benefit from "mainstream" instruction. In this pending case, ACRI obtained a show cause order for a deaf child who was not receiving the 15 hours-a-week instruction in a regular class and the services of a sign-language interpreter that the placement committee deemed necessary.

cally undermines the rights delineated in the S.E.L. and implies that the reform of special education may or may not continue. To adopt this terminology is to suggest that the law itself is not free from the risk of repeal, amendment or further postponement. However, the Budget Law of 1992 did not postpone full implementation of the S.E.L., and hence as of September 1991 the seven-year implementation period began to run.

Despite the somewhat murky status of the 1988 law, legal claims to special education can still arise under the Compulsory Education Act of 1949 and concepts of natural justice.⁷¹ The Israel Association for the Habilitation of the Mentally Handicapped (AKIM), other advocacy groups and parents, often resort to lawyer's letters threatening court action if special education is not provided to a specific child by a specific local education authority. These tactics generally produce the desired results, and petitions to the court often end in informal settlements rather than precedents. *Zeiterburshth v. Ramat Gan Municipality*,⁷² however, had some precedential effect when the High Court of Justice issued a temporary injunction requiring immediate enrollment and transportation to school for a boy with mental retardation. Although the boy had attended an appropriate school for the two prior years and had received free transportation, the transportation was halted without warning at the beginning of a school year and the child received no schooling at all for six months. Within two days of filing an application to the High Court (and the day after the Court issued its injunction), the child received the transportation and schooling that the municipality had claimed posed such great problems.⁷³ In 1990 AKIM framed a claim for additional educational provisions when it presented the Ministry of Education with a draft petition to the High Court of Justice charging that a large private institution lacked classes and teachers to educate residents with mental retardation and multi-handicaps. Before the case could be filed, the Minister agreed to provide the necessary teachers and budget allocations for three special education classes accommodating

71 3 L.S.I. 125, secs. 2, 4(a), 6(a)-(b), 7 & 9.

72 *Zeiterburshth v. Ramat Gan Municipality, Ministry of Education, & others*, H.C. 169/89 (temporary injunction granted 23 February 1989).

73 Interview with Zorach Rosenblum, Tel Aviv attorney for AKIM and the petitioner child (8 August 1991). Following the temporary order, the parties settled, with the petitioners waiving their claims for expenses and attorney's fees in exchange for making the temporary relief final.

some 45 school-excluded children.⁷⁴ Other related disputes focus on overly segregated education of mildly handicapped children and other placement issues.⁷⁵

In addition to claims under the basic education laws that have been saved from derogation by express provisions of the S.E.L.,⁷⁶ litigation — at least in the demonstration project areas — could test whether the law creates some entitlements and enforceable procedural safeguards. Although bureaucratic maneuvers since 1988 may have increased the Ministry's discretion to implement the law nationally, that discretion does not modify the duty to properly refer, evaluate and place children in special education classes in areas in which a placement committee operates.⁷⁷ At present, civil rights organizations and parents' committees on special education have begun to consider legal actions on behalf of children who are at home with no education, in institutions with no education, or in special education classes but requesting "mainstreamed" instruction in regular schools. Although such cases might not be fully adjudicated, past experience suggests that plaintiffs are likely to win favourable settlements in egregious or otherwise factually sympathetic cases.

Compared to international standards or to the U.S. law, Israel has serious deficiencies in achieving the goal of education for all children

74 Interview with Yitzhak Genegar, past-president AKIM Israel & chairman, AKIM Haifa, in Haifa (12 June 1991).

75 For instance, in a recent case brought by a municipality to compel a child's attendance in school, the parents objected to the learning disabled child's restrictive placement in a segregated special class, argued that their child's best interests would be served by placement in a regular classroom, and convinced the court to recommend that priority be given to regular education as specified by the S.E.L. of 1988 and to direct the parties to negotiate a new classroom placement. *Tel Aviv Municipality v. Hadot* (Tel Aviv Juvenile Court, 9 May 1991). Interview with Noga Yaffe, Chairperson, AKIM Jerusalem (9 August 1991). For an international call for integrated education for "all children with challenging needs, however profound those needs may be" and examples from six countries of such educational practice, see International League of Societies for Persons with Mental Handicap, *Education for All: Helping People with Learning Difficulties to be Full Members of their Communities* (1990) 17-39.

76 S.E.L., sec. 22.

77 Four such committees operate in Jerusalem, and others are working effectively in urban and rural areas of the country. Although the Jerusalem committees have been in existence for more than ten years, one new feature is the participation of a delegate of the parents' committees as a member of the placement committee. Interview with Noga Yaffe, *supra* n. 75.

with disabilities. In relation to the relevant UN declarations, the right to education to develop to the individual's maximum potential and to hasten social integration is neither fully realized in law nor in practice.⁷⁸ Many children lack a full day of schooling, an individualized educational plan, or the benefit of their parents' participation in formulating such a plan.⁷⁹ Even though the UN Convention on the Child acknowledges that the right to education is subject to principles of progressive implementation,⁸⁰ the Israeli experience can be criticized for the limited implementation of the S.E.L. law, the virtual suspension of that law during the period of the demonstration project, and the failure to carry out a national plan for special education over a period of time to achieve nationally and internationally recognized human rights objectives. However, as one commentator has noted, a ratifying state would not be in breach of its treaty obligations for incomplete compliance, provided that "a good faith effort is made, considering national resources, to implement the Convention over a period of time",⁸¹ since the Convention's progressive implementation language does not offer a clear-cut standard.⁸²

The Israeli law was in part inspired by the federal Education for All Handicapped Children Act of 1975, therefore comparisons may prove instructive.⁸³ Like the S.E.L., the U.S. law provided for the gradual extension of special education by age category.⁸⁴ However, the basic entitlement to special education for those of compulsory school-age was promptly made effective under the U.S. law. Despite the obstacles to full implementation of this "ambitious Congressional attempt" to mandate an appropriately designed free program of special education for each

78 See UN 1971 Declaration, *supra* n. 20, Art. 2; UN 1975 Declaration, *supra* n. 21, Art. 6.

79 Interview with Dr. Rimmerman, *supra* n. 65.

80 UN Convention on the Rights of the Child, *supra* n. 31, Art. 28(1).

81 C. Cohen, *supra* n. 44, at 44-45.

82 *Ibid.*, stipulating that the child's right to education shall be achieved "progressively and on the basis of equal opportunity . . .".

83 20 U.S.C.A. §§ 1400-1485 (West Supp. 1991). The law is now named the "Individuals with Disabilities Education Act". *Ibid.*, § 1400 (a).

84 The U.S. law provided that "a free appropriate public education" must be available for all children with disabilities between the ages of three and eighteen not later than September 1, 1978, and for all children with disabilities between the ages of three and twenty-one not later than September 1, 1980. 20 U.S.C.A. § 1412(2)(B) (West Supp. 1991).

handicapped child,⁸⁵ this Act has aided millions of handicapped children and their families.⁸⁶ Such children's rights to appropriate education in the least restrictive educational environment are now recognized by the federal government, the 50 states, and the District of Columbia.⁸⁷ In disputes over what constitutes the appropriate individualized educational program (I.E.P.), the school system bears the burden of proof, and parents can invoke elaborate due process safeguards in matters of identification, evaluation and placement. Parents may also recoup their attorneys' fees, including the related costs of expert testimony, if they are the prevailing party in a court action or administrative hearing to vindicate their child's special educational rights.⁸⁸ A substantial body of case law and statutes now affirms that even the most severely handicapped child has the right to attend a full and free school program.⁸⁹ Such a program must be based on an individualized educational plan from which the child can be expected to benefit.⁹⁰ Although Israel is unlikely to have so legalized a system of special education,⁹¹ a successful test case and an invigorated lobbying campaign could stimulate the

85 *Rabinowitz v. New Jersey State Board of Education*, 550 F. Supp. 481, 485 (D.N.J. 1982). On the difficulties in altering the conduct of school officials in the early implementation of special education legal reforms, see J. Handler, *Protecting the Social Service Client: Legal and Structural Controls on Official Discretion* (1979) 61-67.

86 U.S. Dept. of Education, *Tenth Annual Report to Congress on the Implementation of the Education of the Handicapped Act* (1988). The federal government's annual subsidy for special education exceeds \$2.123 billion, with the bulk of special education expenditures defrayed by state and local governments.

87 See generally, L. Rothstein, *Special Education Law* (1990); H. Turnbull, *Free Appropriate Public Education: The Law and Children with Disabilities* (3rd ed., 1990).

88 Handicapped Children's Protection Act of 1986, P.L. 99-372, codified at 20 U.S.C. § 1415 (e)(4) (1988).

89 See generally J. Wegner, "Educational Rights of Handicapped Children: Three Federal Statutes and an Evolving Jurisprudence", (1988) 17 J. L. & Educ. 387, 625, (parts 1 & 2).

90 *Board of Education of the Hendrick Hudson Central School District v. Rowley*, 458 U.S. 176 (1982); *Tatro v. Texas*, 468 U.S. 883 (1984); *School Committee of the Town of Burlington v. Dept. of Education of Massachusetts*, 471 U.S. 359 (1985); *Honig v. Doe*, 484 U.S. 305 (1988).

91 See D. Neal & D. Kirp, "The Allure of Legalization Reconsidered: The Case of Special Education", (1985) 48 L. & Contemp. Probs. 63; D. Jung & D. Kirp, "Law as an Instrument of Educational Policy-Making", (1984) 32 Am. J. Comp. L. 625, at 651-58.

relevant political actors to fuller implementation of the promising 1988 law and the Israeli child's entitlement to special education.

C. Rights to Developmental Services

In the field of developmental services, Israeli law and practice reflect highly institutionalized models of treatment and care. The Welfare (Treatment of Retarded Persons) Law, 1969⁹² is based on a medical-welfare model rather than the developmental model characteristic of the more modern Special Education Law. The medical model is reflected in terminology that defines a retarded person in terms of "need of treatment", and the appropriate forms of assistance as "prescribing a mode of treatment".⁹³ The welfare model is expressed through the broad powers vested in a welfare officer to exercise emergency powers, to examine any retarded person, to bring such persons to the attention of an evaluation board or a court, to initiate periodic reviews, and to carry into effect compulsory measures that the officer recommends and the court approves.⁹⁴

Under the welfare model, the Ministry of Social Welfare (renamed the Ministry of Labour and Social Affairs) primarily funds services in institutions and requires compulsory identification of every retarded person. Under penalty of criminal fine, any physician, or "employee of a welfare, health or education service" is obligated to notify a welfare officer that a person contacted in the course of work is suspected of being retarded.⁹⁵ The welfare officer must then examine the case of the individual brought to the officer's attention by notification or otherwise. The officer has the discretion to forward such cases to an evaluation board for further examinations and a decision as to the appropriate mode of treatment. The retarded person and the person "in charge of him" must have a "suitable opportunity to be heard" before that decision, and have the right to object to the decision before an objection board. At this quasi-judicial hearing, the person and his or her custodian must again have a suitable prior opportunity to be heard. The board has three options:

92 23 L.S.I. 144.

93 *Ibid.*, secs. 1, 7(b), 10(3).

94 *Ibid.*, secs. 4, 5, 6, 9, 11-12, 15, 16. The welfare officer is defined as a qualified welfare worker appointed by the Minister of Labour and Social Affairs.

95 *Ibid.*, sec. 3(a).

dismissal of the objection, allowance of the objection in cases where the person is not retarded and not in need of treatment under this law, or allowance with remand to the evaluation board for the purpose of further examinations and new treatment prescriptions. The board appears to have no power to order an alternative, less restrictive mode of treatment, or to otherwise vary the treatment.

At least once every three years, the welfare officer shall submit the retarded person's case for review by the evaluation board. Such a review may also be initiated at any time by the officer or the person in charge of the retarded person.⁹⁶ Judicial review is limited to cases of compulsion where the person or custodian resists examination or the prescribed mode of treatment, or where the welfare officer believes that the "retarded person or another person is in immediate danger" or the retarded person needs urgent treatment.⁹⁷ A striking feature of the latter emergency provisions is that the welfare officer can act unilaterally, subject only to notifying the court after the fact and convincing the court not to exercise its power to "vary or annul those measures".⁹⁸

This law appears outdated in several respects. First, it is almost devoid of references to the rights of clients. The one exception is the right of the retarded person and the person's custodian to be notified of their right to object to the evaluation board's decision before an objection board.⁹⁹ Second, as a product of the 1960s when the legal rights of persons with mental retardation were not adequately addressed in most countries, the law provides no framework for community-based services, or determinations of the appropriate least-restrictive alternative. Third, the law reflects not only an intense paternalism towards persons with special needs, but a skepticism that their parents or other custodians will bring them forward for treatment. For instance, the compulsory identification provision, previously discussed, is sometimes justified in terms of fears that Arabs or Jewish immigrants from cultures where the

96 *Ibid.*, sec. 15(a). The law does not expressly provide the affected person or a concerned organization with the means to obtain such review.

97 *Ibid.*, sec. 16. This provision empowers the welfare officer to take sweeping action, without the consent of the retarded person or the person's custodian and without review by an evaluation board, and to "adopt every measure which, in his opinion, is necessary in order to avert that danger or provide that treatment".

98 *Ibid.*, sec. 16(b). A case invoking this power is discussed *infra* text accompanying nn. 165-169.

99 *Ibid.*, sec. 8. The duty to provide periodic evaluation at least once in three years for persons under care is also expressed in mandatory language.

stigma of having a retarded child is especially strong, would "hide" such a child and not seek essential treatment.¹⁰⁰ Fourth, the law is largely silent as to the affirmative rights of persons in residential care, the burdens of proof and procedures for challenging the person's identification, evaluation, waiting-list status and/or placement, and the adequacy of habilitation or treatment offered.¹⁰¹ Fifth, in stark contrast with the Special Education Law, the 1969 law neither promotes parental participation in decision-making concerning their child nor guarantees the delivery of least restrictive alternatives. Sixth, the law vests enormous power in a single uncredentialed "welfare officer" in contrast to the contemporary model of interdisciplinary review. Seventh, with the worldwide advances in professional care and recognition of the human rights of persons with mental retardation over the last two decades, the 1969 law appears ripe for thorough review and replacement.

Even under this archaic law, court actions can and do arise for maltreatment or other wrongs. In 1986, as a result of a police undercover investigation following complaints by overseas volunteers, six staff members of the Ruchama institution were convicted and imprisoned for physical abuse of residents.¹⁰² Although an earlier criminal prosecution concerning alleged neglect of residents of an 80-bed private institution for the mentally retarded, Beit Tina, was suspended by the Attorney-General, that institution was closed after the court action sparked a special investigating committee's findings of inhumane treatment and poor diet suffered by the residents.¹⁰³

To date, precedent appears lacking in civil litigation. Few complaints are filed and legal predictions for success under existing law are guarded.

100 Interview with Avraham Levine, Director, Department of International Relations, Ministry of Labour & Social Affairs, Jerusalem (11 June 1991).

101 Administrators may respond that the law's generality encourages flexible and creative solutions. There are, however, some regulations on the management of "homes" that deal with physical conditions in institutions. Such regulations are subject to veto by the Ministry of Finance if their impact is too costly. Announcements and notices issued by the Ministry of Labour, although lacking the force of law, provide the mental retardation department with some guidance on standards and norms. Advocates could in turn argue that these standards are social rights to be secured through negotiation and other actions.

102 Interview with Tami Shwartz, Ruchama institution social worker, in Ra'anana (11 July 1991). For chronicles of abuses in institutions, see C. Aharoni, *By Right and Not By Charity* (1988; in Hebrew) 281-329; C. Aharoni, *You Are Right, But . . .* (1990, in Hebrew) 264-87.

103 Interview with Prof. Dan Shnit, Tel Aviv University School of Social Work (2 July 1991).

According to a respected commentator, a person institutionalized according to the correct procedures would be unlikely to obtain a judicial remedy for community placement, even if it could be proved that such placement would be better for the person.¹⁰⁴ The case of *Shem-Tov v. Director of Rehabilitation Ministry of Labour and Social Affairs*¹⁰⁵ offers an encouraging exception, at least for persons whose needs are misdiagnosed. In 1991, the Association for Civil Rights in Israel (ACRI) filed an injunctive action to secure the release of two brothers erroneously confined for twenty years in the Swedish Village, an institution for the retarded, even though they were not retarded but suffered from a type of cerebral palsy. Counsel argued that though the institution had discovered their true diagnosis at least as early as 1989, they remained in a setting inappropriate to their condition and harmful to their well-being. It was further alleged that the Ministry of Labour & Social Affairs and others had been notified of the brothers' misplacement, but had not acted to transfer them to an appropriate group home for persons with cerebral palsy. The High Court of Justice granted their show cause order requiring the Director of Rehabilitation, the Labour Minister, and "Ilan" (an organization operating a home for the physically disabled) to explain why the plaintiffs were not transferred from the mental retardation institution to the community-based group home. To settle the case, the respondents agreed to place the brothers in the desired, less-restrictive group home offering them better treatment, and requested that the suit be dismissed. Although *Shem-Tov* produced no precedent, it demonstrated the feasibility and efficacy of challenging a clearly inappropriate institutional placement in the courts.

Similar cases could test the provisions of the 1969 law that require periodic review at least every three years. Unfortunately those requirements appear to be flouted in practice.¹⁰⁶ Although the Knesset has questioned the director of the mental retardation services on this appar-

104 D. Shnit, *supra* n. 55, at 292-293.

105 96/91 H.C., (filed 15 January 1991).

106 In interviews and other meetings, social workers in institutions acknowledge that they know of one or more persons in each facility who are not mentally retarded. They also confirm that many mildly retarded and other residents have not been reevaluated for 20 or even 30 years. In explaining why those residents' rights are ignored, they cite parents who lack the strength to fight the system, parents who are resistant or fearful of any change in their adult child's place of residence, clients over age 50 who are now adapted to institutional routines, and the social workers' limited ability to advocate for their clients' rights.

ent breach of law, the response received was that staff were otherwise occupied and that the law should be changed, at least for older retarded persons. To date, no amendment to this legal requirement has been proposed. Furthermore, the existing legislative scheme embraces the concept that all persons with mental retardation shall be identified with a view to their being properly referred, evaluated, and provided with treatment services. These services are to be provided to mentally retarded persons and their families in a sequence of treatments throughout their lives, and include diagnosis, services in educational, rehabilitative and vocational settings, leisure-time services and community services of various types, such as hostels and group homes.¹⁰⁷ Israeli lawyers and courts have yet to explore the human rights implications of this legislative design and the underlying regulations, instructions and administrative announcements.¹⁰⁸ However, a case prepared by ACRI and others tests the legality of leaving a severely disabled teenage boy at home without any day or residential services and the mere placement of the names of such persons on a waiting list for services.¹⁰⁹

Substantial evidence exists that Israel's system of residential services fails to meet international human rights norms. Problems of misplacement resulted from the lack of professionalism, evaluations for placement based more on impression than on carefully considered test results, and the fact that periodic re-evaluations at regular interviews were seldom done.¹¹⁰ Furthermore, the State Comptroller strongly criti-

107 Ministry of Labour and Social Affairs, *Instruction 14.1: Policy of Ministry about Treating the Retarded*, para. 1.3 (31 January 1989) (in Hebrew).

108 See, e.g., *ibid.*, para. 2.4 states "Treatment programs [in a normative] framework should be comprehensive and unique, relating to the special needs of the retarded person and his family. They will be continuous and flexible because the needs are changing from one developmental stage to another. The treatment programs will be in various areas: increasing independence in daily life, vocational rehabilitation, sexual-social education, etc. The programs are adapted for all retardation levels".

109 *Anonymous v. Ministry of Labour and Social Affairs*, filed in October 1991 in the High Court of Justice. The state has responded that with a limited budget it is doing the best it can to meet the needs of the various populations to be served, and ACRI has countered with factual discovery requests. Letter from Neta Ziv Goldman, Director, Litigation Center of ACRI, to Stanley S. Herr (3 May 1992).

110 See n. 106, *supra* and class presentation to MSW graduate students by Dr. Arik Rimmerman, Senior Lecturer, Bar-Ilan University (5 June 1991) (erroneous institutionalization from childhood of a man with an IQ of 115 and exceptional mathematical abilities in part because he was an immigrant without parents and lacked knowledge of Hebrew). Interview with Jane Doe, social worker (3 June 1991) reporting that at least six persons who are not retarded or of borderline intelligence are on her institutional caseload.

cized the breach of the statutory duty to evaluate periodically the clients and their treatment needs, noting that in a random survey of 56 files, 47 residents had not been reevaluated since their initial assessment.¹¹¹ Although limited efforts at deinstitutionalization have begun, the system is highly institution based, with over 90% of the beds for out-of-home placement in institutions.¹¹² The budget for residential care of the Mental Retardation Service of the Ministry of Labour & Social Affairs reflects a similar imbalance, with 94% going to institutional services, and only 4% devoted to community-based group homes, foster care, or sheltered apartments.¹¹³ Although the municipalities provide some community services from their own budgets, the national Mental Retardation Service uses 97% of its available funds for out-of-home care, and thus can give only limited resources to support family or independent living arrangements.

These budgetary and policy decisions preclude compliance with the UN Declaration on the Rights of Mentally Retarded Persons, which states that "whenever possible, the mentally retarded person should live with his own family or with foster parents" and otherwise participate in community life.¹¹⁴ The gap between the subsequent UN Declaration on the Rights of Disabled Persons and the Israeli reality is even wider, since many such persons with mental retardation are institutionalized not because a stay in such a facility is "indispensable" or required to improve the individual's development,¹¹⁵ but because other forms of

111 State Comptroller, "Report on Residential Facilities for the Mentally Retarded", in *37th Annual Report* (1988) 473-481.

112 As of August 1991, some 5600 persons were in institutions with over 16 beds, and only 440 persons in group homes, hostels, foster families, and sheltered apartments in the community. Interview with Stefan Rothschild, Deputy Director, AKIM Jerusalem (14 June 1991).

113 Ministry of Labour and Social Affairs, *Report of Deputy Minister Rabbi Porush to the Knesset on Activities and Plans of the Ministry of Labour and Social Affairs* (1991, in Hebrew). Of the Ministry's overall budget, 28.6% goes to mental retardation services.

114 UN, *supra* n. 20, Art. 4.

115 UN, *supra* n. 21, Art. 9. This provision also categorically states that "[n]o disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom".

family support or more normalized residential services are simply unavailable as a result of the government-created configuration of services.¹¹⁶ These problems of imbalance and scarcity are aggravated by the government's effective monopoly over the provision of mental retardation care, since no one can enter an existing residential facility or even create a community facility without being processed through the Ministry's centralized waiting-lists.¹¹⁷

Other institutional practices have been criticized by the State Comptroller and appear to contravene domestic as well as international human rights standards. With respect to the UN declarations' normalization and developmental principles, such deficiencies include: lack of therapy services, lack of trained personnel, insufficient educational activities and educational plans for residents, failure to provide periodic medical examinations, lack of adequate medical and dental records, overcrowding, lack of vocational activities and resulting idleness of residents, and poor environmental conditions.¹¹⁸

In contrast to the paucity of Israeli legal cases in this field,¹¹⁹ the U.S. judiciary has frequently declared and enforced the rights of Americans

116 Compare these realities to Ministry of Labour and Social Affairs, *Instruction 14.1: Policy of Ministry about Treating the Retarded*, para 2.3 (31 January 1989, in Hebrew) which states: "The normalization principle requires giving services in a normative framework in the least restrictive form. The aim is that the retarded person will stay at home until the age of leaving home and stay in his natural community. If there is a need for living outside the family, it will be close to home. The services will resemble the regular services in the area".

117 By August 1991, 770 persons were on the waiting list for a place in an institution, 660 persons for day care, 250 persons for a sheltered workshop, and 200 persons for a community-based hostel or group home. Interview with Amir Schwartz, Mental Retardation Service, Ministry of Labour & Social Affairs (12 August 1991).

118 State Comptroller, *supra* n. 111.

119 See, e.g., unpublished cases in which community-based group homes for persons with mental retardation have been named as defendants in complaints by neighbours of nuisance [*Beit Isadore Shapiro* case, case dismissed by District Court, 1984] or by municipal officials in allegations of zoning and licensing violations [*Planning Council v. Rehabilitative Education Institute*, District Court case on Rosh Ha'Ayin hostel resolved by agreement that despite zoning violation, hostel would remain open and operate under the supervision of the municipality and the Welfare Ministry] and cases on individual rights discussed in Section III. D., *infra*.

with mental disabilities in a wide array of settings.¹²⁰ In one leading case, *New York State Association for Retarded Children v. Rockefeller*,¹²¹ 2600 of the Willowbrook State School's 5400 residents were transferred over a six-year period to community-living arrangements that were decent, safe and habilitative.¹²² Over the last two decades, 24 such developmental institutions in twelve states have been closed or scheduled for closure, often as result of judicial implementation of right-to-habilitation orders.¹²³ An empirical study of the outcome of transfers from one of those institutions concluded that residents showed considerable progress in many behavioural areas and spent more time in programmed activities after the transfer. Furthermore, over 94% of the families of transferred residents were satisfied with the services at the receiving facilities.¹²⁴ These implementation studies have demonstrated that "even the most handicapped and long-term institutional residents can be returned to the community and benefit from it".¹²⁵ Judicial implementation of such decrees is, however, time-consuming and re-

120 See S. Brakel, J. Parry & B. Weiner, *The Mentally Disabled and the Law* (3rd ed., 1985); M. Perlin, *Mental Disability Law: Civil and Criminal* (1989) (three volumes). For the landmark right to treatment case, see *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) (right to treatment in state mental hospitals), *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972) (right to habilitation in mental retardation institutions), *aff'd in part sub nom., Wyatt v. Aderholt*, 503 F.2d 1305 (1974). *Wyatt* has been cited as precedent in over 174 cases and achieved a profound impact on the rights of mentally disabled persons in Alabama and elsewhere in the United States. *Wyatt v. Stickney: Retrospect and Prospect*, L. Jones & R. Parlour, eds., (1981) 111.

121 357 F. Supp. 752 (E.D.N.Y. 1973), *consent decree approved* 393 F. Supp. 715 (E.D.N.Y. 1975). For discussion of the legal theory of the case, see S. Herr, *Rights and Advocacy for Retarded People* (1983) 123-36, 181-89.

122 D. Rothman & S. Rothman, *The Willowbrook Wars: A Decade of Struggle for Social Justice* (1984) 353. Due to ongoing advocacy, elaborate safeguards and careful monitoring, there was no "dumping" of the Willowbrook residents on unprepared neighbourhoods and the problems that had attended the earlier wave of deinstitutionalization of the mentally ill were largely avoided in the field of developmental disabilities. See *ibid.*, at 353-354. By 1988, Willowbrook was closed and replaced by a network of community-based support services.

123 T. Heller & D. Braddock, *The Closure of the Dixon Developmental Center: Final Report* (University of Illinois at Chicago, Institute for the Study of Developmental Disabilities, Public Policy Monograph Series, No. 23, Feb. 1986) 3.

124 *Ibid.*, at 90, 92.

125 D. Rothman & S. Rothman, *supra* n. 122, at 354.

quires ongoing vigilance by counsel and organizations representing the plaintiff class.¹²⁶

Viewed from these perspectives, Israeli society faces many challenges in “creating a humane and growth-enhancing environment”¹²⁷ for all of its citizens with mental retardation. Some municipalities and members of the public have been resistant to developing community services in the past.¹²⁸ Professionals, rather than parents, have often had to provide leadership for the development of community services, but often lacked the knowledge base and political support to “build a strong movement in favour of deinstitutionalization”.¹²⁹ Finally, with no Israeli legislation to foster community-based services,¹³⁰ and no supportive judicial precedents, legal protection for treatment rights in the community is weak or nonexistent. While the government adopted the rhetoric of “community living for retarded people”,¹³¹ the law and practice lag behind.

D. Individual Rights

Since the human rights of the ordinary Israeli are not given entirely adequate legal protection,¹³² it is not surprising that the individual

126 On the availability of class action remedies in Israel, see S. Goldstein, “Class Actions in Israel”, in *Israeli Reports to the XIII International Congress of Comparative Law*, C. Fassberg, ed. (Jerusalem, 1990) 45.

127 Y. Wozner, *People Care in Institutions: A Conceptual Schema and its Application* (1990) 1.

128 M. Hovav, “Service for the Retarded: Basic Problems and Programs”, in Association for the Planning and Development of Community Services for Retarded in Israel, *A Reader on Mental Retardation* (JDC/Israel 1979). Dr. Meir Hovav was then Director of the Social Welfare Ministry’s Service for the Retarded.

129 M. Hovav, “Deinstitutionalization of the Retarded and Integration Into the Community (Israel)”, in *Proceedings of United States-Israel Bilateral Conference on Self-Sufficiency, Appropriate Care, and Deinstitutionalization of Developmentally Disabled Persons, Children at Risk and Aging Persons* (Temple University, Developmental Disabilities Center, June 12-15, 1983) 127, 128.

130 *Ibid.*, at 128.

131 *Ibid.*, at 131. According to its chief, the “government’s Service for the Retarded recognized the need to implement the ideology of taking residents out of institutions”.

132 I. Zamir, “Human Rights and National Security”, (1989) 23 Is. L. R. 375; I. Zamir, “Rule of Law and Civil Liberties in Israel” (1988) 7 Civil Justice Q. 64. See, e.g., Editorial: “Legalized Burglary”, *Jerusalem Post*, 31 July 1991, p. 6 (criticizing Israel Broadcasting Authority for using its legal entitlement to break into homes to seize property for payment of television license fees).

rights of persons with mental disabilities are also at risk. As previously discussed, the 1969 mental retardation law gives the subject scant attention. The Safety of Protected Persons Law, 1966 permits a court to order medical treatment against the will of a person incapable of providing himself with the necessities of life on the grounds that the person's well-being is likely to be impaired and the person is "mentally defective or opposes treatment on unreasonable grounds".¹³³ Thus, a person alleged to have an undefined mental defect may be forced to accept treatment that he or she opposes on reasonable grounds.

The new mental health legislation, while an improvement from a civil liberties point of view over the Treatment of the Mentally Sick Persons Law, 1955,¹³⁴ still leans heavily toward paternalism and treatment over patient autonomy and liberty. The 1955 act made explicit only two patients' rights: the right to correspond and the right to receive visitors. Even these rights were not absolute, and were subject to limitation by the hospital director for medical reasons.¹³⁵ That law lacked any reference to the right to receive treatment in the least restrictive manner or the right to refuse treatment. Professors Shnit and Aviram have criticized this lack of rights, as well as the imbalance between the hospital's interest in operating an efficient and safe medical system and the patient's interests in privacy and liberty.¹³⁶ They also faulted the system for not even meeting the requirements of a deficient law and for burdening the law's key gatekeeper — the District Psychiatrist — with three incongruent and conflicting roles. Rather than occupying an independent position, this individual might simultaneously be the hospital director and thus be required to perform quasi-judicial, executive and supervisory roles.

The recent Treatment of Mentally Sick Persons Law, enacted in January 1991, has been hailed by the Ministry of Health as "a major advance in the procedural and substantive rights of the mentally ill in Israel".¹³⁷ From this perspective, the law was strengthened by: the

133 20 L.S.I. 48, sec. 6 (emphasis added). See *ibid.*, secs. 1, 4-5.

134 9 L.S.I. 132.

135 *Ibid.*, sec. 26(a)-(b).

136 U. Aviram & D. Shnit, *Psychiatric Treatment and Civil Liberties: The Involuntary Hospitalization of the Mentally Ill in Israel* (1981, in Hebrew); and the authors' English-language articles cited at n. 53, *supra*.

137 S.H. 1339, p. 58. Ministry of Health, Office of Legal Adviser and Mental Health Services, "The Law of Care of the Mentally Ill, 1991" (14 June 1991).

requirement of automatic review by the psychiatric committee of each patient involuntarily hospitalized for more than two weeks; the authority of the district psychiatrist to order compulsory examination only, without compulsory admission to hospital; the requirement of posting of patients' rights on the wards as well as direct notification to patients of those rights by written and oral means; the right of voluntary patients to refuse treatment; and the right of all patients to receive information about their condition and to participate in the planning of their treatment and rehabilitation.¹³⁸ In addition, the standard of proof for involuntary commitment was tightened somewhat by requiring that a district psychiatrist have "clear-cut indications" rather than convincing evidence that the commitment criteria were met.¹³⁹

In other respects, civil libertarians lost ground or made little headway. The basis for commitment was broadened under the new law. Instead of a test focusing exclusively on dangerousness, patients can now be committed against their will if found gravely disabled and limited in meeting basic needs or posing a serious interference with the lifestyle of their households.¹⁴⁰ Furthermore, the law adds a provision for involuntary commitment on an outpatient basis.¹⁴¹ Although officials claim that this is "a less damaging alternative to [protecting] patients rights", this power also expands the sphere for coercive psychiatric care and the population whose rights can be restricted.¹⁴² Although "ENOSH" (the Israel Mental Health Association) and civil liberties groups campaigned for the rights to aftercare and to treatment in the least restrictive alternative, such proposals were not included in the law.

Under previous legislation, a few court judgments explored the rights of mentally disabled persons. In *Yarmilowitz and the State of Israel v. Hovav*,¹⁴³ the Supreme Court ruled that an individual could be commit-

138 Treatment of Mentally Sick Persons Law, 1991, secs. 6, 10(c), 35. Interview with Joshua Schoffman, Legal Director, ACRI, in Jerusalem (3 January 1991). These changes were viewed by many psychiatrists as necessary and even "revolutionary", substituting lax modes of admission with stricter oversight. Interview with Dr. Peter Silfen, Director of Mental Health Services at Ramle Prison, in Ramle (12 July 1991).

139 *Ibid.*, sec. 9.

140 *Ibid.*, sec. 6. Although ACRI accepted these additional grounds for committal as part of an overall legislative compromise, their decision followed an internal debate.

141 Treatment of Mentally Sick Persons Law, 1991; Schoffman Interview, *supra* n. 138.

142 Cf. Israel Ministry of Health, "The Law of Care of the Mentally Ill", *supra* n. 137, at 2 with S. Schwartz & C. Costanzo, "Compelling Treatment in the Community: Distorted Doctrines and Violated Values" (1987) 20 Loyola L.A.L. R. 1329.

143 *Yarmilowitz v. Hovav*, (1981) 35(iii) P.D. 767.

ted against his will without first being examined by the District Psychiatrist or someone acting on his behalf, and without the right to have an opportunity to be heard before this deprivation of liberty in vaguely defined circumstances of emergency. Although the Court criticized many aspects of the law, it concluded that the Knesset had intended mental hospitalization to be within the domain of medicine. In *Roth v. State of Israel*,¹⁴⁴ the Court upheld the power of psychiatrists to examine or hospitalize a patient involuntarily in order to protect the public or the patient, or for the purpose of providing medical treatment to the patient. Although judges in criminal proceedings were admonished not to order mental examinations simply because it might lead to future medical treatment or be claimed to be for the patients' "own good",¹⁴⁵ the Court emphasized the medical model and the broad discretion of psychiatrists to disregard any court order at variance with their own professional opinion.¹⁴⁶ Such judgments have been criticized as unreasonably limiting the application of principles of natural justice in matters of fundamental human rights and as offering little guidance in defining dangerousness or the degree or imminence of danger warranting compulsory measures.¹⁴⁷

144 *Roth v. State of Israel*, (1977) 31(ii) P.D. 757.

145 The Supreme Court noted that in a misdemeanor case where the accused refuses to submit to a mental examination and is willing to accept his criminal responsibility, a judge should make a particularized finding that a compulsory examination is justified by public interests that outweigh the liberty interests of the defendant.

146 "As far as the district psychiatrist is concerned, it does not matter at all that the court has made an examination (or hospitalization) order; any such order is always deemed to be subject to the particular psychiatrist's medical opinion Not in vain did the legislature remove execution of the Orders for Examination (and commitment orders) from the judicial authorities and hand them over to the medical authorities. The purpose of the law — as the name implies — is to treat mentally sick persons, and all the powers and remedies laid down in it are intended to advance and make efficient that treatment".

147 Shnit, "Limitations on the Right of the Mentally Ill to be Heard: Exception or Error?", (1982) 12 Is. Yrbk. Human Rights 195, at 213. For a critique of the medicalization of mental health services and the dominance of mental hospital approaches to patient care, see U. Aviram, "Mental Health Policy and Programs in Israel: Trends and Problems of a Developing System", (1991) 18 J. Sociology & Soc. Welfare 89, at 117-22.

Voluntary patients have also had limited success in protecting their rights through litigation. At least two published decisions have ruled against the claims of such patients.¹⁴⁸

Anonymous v. State of Israel,¹⁴⁹ in contrast, proved protective of an involuntary patient's rights and exposed serious flaws in the review procedures. In that case, the District Court upheld the patient's appeal from a decision of the psychiatric committee. Although the 25-year-old patient was hospitalized on grounds of dangerousness by order of the district psychiatrist, the court found a host of procedural and evidentiary irregularities in the psychiatric committee's perfunctory review. The court held that the committee as a quasi-judicial body had failed to create a proper record and remanded the case to the committee for a new hearing and proper record that the court could review. Specifically, the committee had failed to provide the court with: the patient's file; a list of the witnesses who testified or their tests, including whether or not the district psychiatrist appeared; any documentary evidence; or reasons for the committee's decision other than the conclusory statement that the patient needed hospitalization. Even though it authorized continued confinement, the committee itself had not reviewed the hospital file, had no evidence of the patient's alleged dangerous acts prior to his hospitalization, had no direct evidence of the patient's examination or diagnosis, and had made no findings of the patient's dangerousness to self or others as required by the statute.¹⁵⁰

148 *Raguan v. Director of Be'er Yaacov Hospital*, (1964) 18(iii) P.D. 259 (director can retain voluntary patient who seeks release even though the patient is not dangerous). In *Carmelli Mazal v. State of Israel*, (1987) 41(iii) P.D. 757, decided in 1986, the defendants were not liable to a voluntary patient incorrectly detained in that status who had objected to hospitalization since the court found no injury because of indications that she could have been involuntarily hospitalized. The *Carmelli* decision can be criticized since whether or not she would have been held involuntarily is speculative and detaining a voluntary patient against her will is a deprivation of the right to have one's case reviewed by the District Psychiatrist. In an unpublished prior case, the plaintiff in a comparable malpractice case obtained an out-of-court settlement of 20,000 shekels. A similar result would be unlikely after *Carmelli*. Interview with Professor Dan Shnit, Tel Aviv University (10 July 1991).

149 Tel Aviv District Court, 512/88 (19 June 1988), (1989) 1 *District Court Reporter* 126.

150 *Ibid.* Factors that may have contributed to this vindication of the patient's rights were his legal representation by two able ACRI attorneys, the family support and visits he received while in hospital, and his other social contacts. For a Supreme Court case remanding a mental patient's commitment order for District Court review despite the patient's confused allegations, see *Rothbard v. State of Israel*, H.C. 813/87 (25 September 1989).

In light of this history, it is difficult to predict that the new mental health law will produce substantial changes in either patient care or the protection of individual rights. Although the law went into effect in April 1991, the early stages of implementation have been marked by confusion. No regulation or other instruction had been issued on how to carry out the law, and even experienced psychiatrists reported uncertainty as to how to apply the law and to train staff to understand its lengthy and complicated provisions.¹⁵¹ Much will depend on the quality of the automatic reviews conducted by the psychiatric committees, the training of personnel to accept and apply new procedures and rights, and the availability of monitoring and advocacy to ensure that the law is faithfully implemented. Yet even the strongest legal safeguards are not likely to be effective if resources are inadequate or if they operate in "an inherently therapeutic environment".¹⁵² For despite admonitions by managers to comply strictly with the law, in such an environment the temptations are great to circumvent the law, cut corners, or disregard what are viewed as the law's unrealistic requirements.¹⁵³

Although the Israeli mental health system aspires to provide therapeutic environments, it is constrained by the virtual absence of community-based residential facilities as an alternative to hospitalization. There are a total of 7059 beds for mental patients in hospitals, but only 160 beds in community residences.¹⁵⁴ While the system seeks to expand the number of places in hostels and sheltered apartments, an estimated one-third of the hospital patients cannot be released for lack of adequate

151 These conditions prevailed at least through August 1991 when the author conducted a series of non-random interviews with district and other senior psychiatrists. See J. Levi, "Legislation: Israel", (Oct. 1991) 3 Int'l B. L. & Mental Health 31 ("Alas, the Minister of Health has not promulgated regulations which he ought to enact according to the law").

152 J. Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (1989) 202.

153 See *ibid.*, at 202-14, 231-32 (describing England's more legalized regulation of mental care). In closed wards for the more severely mentally ill patients, staff may experience "burnout" and feel estranged from patients and civil-rights groups advocating for patients' rights. J. Siegel-Itzkovich, "Lending an Ear to Mental-Health Staff", *Jerusalem Post*, 2 June 1991, p. 5 (citing article by R. Durst, N. Oren, A. Vass & Y. Ginat in the *Israel J. of Psychiatry & Related Sciences*).

154 Ministry of Health, Information Systems on Mental Health, "Total Patient Movement in Hospitals and Hospital Units for Mental Health Care" (13 June 1991) (in Hebrew).

community services.¹⁵⁵ Although many mental health workers profess interest in expanding community-based care, the reality is that they often find it more convenient to work in institutional settings and are reluctant to battle the stigma and neighbourhood resistance that may accompany the return of a significant number of ex-mental patients to the community.

Judges, like mental disability professionals, may also favour paternalistic approaches over individual rights where the individual is under a disability or needs treatment. The recent case of *Anonymous v. Vardi Jack* involved a seventeen and one-half year-old youth who petitioned for his release from enforced mental hospitalization where he had been kept in a locked ward for the sole purpose of coerced chemotherapy treatment for cancer.¹⁵⁶ The Juvenile Court ordered this hospitalization under the Youth (Care and Supervision) Law, 1960,¹⁵⁷ despite a lack of any evidence of mental illness, because the minor refused to submit to what he regarded as painful and futile treatment and instead preferred homeopathic treatment. The Supreme Court convinced the youth to accept this treatment in order to gain his release from psychiatric hospitalization, and received his reluctant undertaking to present himself as an outpatient for chemotherapy despite the pain, discomfort, and mental distress he reported.¹⁵⁸ The Court then remanded the matter to the Juvenile Court, released the youth from the psychiatric department to the custody of his parents, and left to the Juvenile Court any further decisions relating to his undertaking to receive chemotherapy treatment. The medical profession's judgment was more emphatic, as representatives of the Israel Medical Association condemned this forced hospitalization as "in violation of medical ethics" since the young man did not suffer from mental illness or meet other strict criteria for compulsory care in a mental ward.¹⁵⁹

155 Interview with Dr. George Szekely, Director, Mental Health Services, Ministry of Health, in Jerusalem (8 July 1991). The State Comptroller also noted the lack of community services in annual reports published in 1976, 1980 and 1991.

156 2098/91 H.C. (23 May 1991).

157 14 L.S.I. 44, secs. 2(2) & 2(6).

158 In an Israel radio interview, the youth stated that he only agreed to undergo chemotherapy "in order to free myself from the psychiatric ward where I have been for a month, I am not mentally ill". He also declared his wishes to "get any other cancer treatment but chemotherapy" and to be otherwise left alone. J. Siegel, "Young cancer patient out of mental ward after reluctantly agreeing to chemotherapy", *Jerusalem Post*, 24 May 1991, p. 2.

159 J. Siegel, "Putting cancer victim in psychiatric ward is unethical — IMA head", *Jerusalem Post*, 27 May 1991, p. 10.

Although the Israel Supreme Court avoided ruling on the difficult legal questions presented in balancing the individual's freedom with his well-being, the concession it extracted in court collapsed when the youth again refused to accept the conventional medical treatment.¹⁶⁰ To avoid further traumatic encounters with the legal and medical professions, the youth ran away from home, flew to the United States and obtained fresh medical advice from experts on treatment alternatives at New York's Sloan-Kettering Cancer Institute. Despite the good intentions of the Juvenile Court, this tragic case suggests the shortcomings of coercive paternalistic approaches to patients who struggle for self-determination at the edge of adulthood.

Other recent cases display the variety of human rights claims that Israeli courts confront. In *AKIM v. Deputy Minister Porush*, parents of residents of an institution run by Catholic nuns and organizations for the retarded challenged the Deputy Minister's attempts to forbid severely retarded Jewish youngsters from being served in a Catholic institution. As grounds for their request for a show cause order, the parents objected to the interference with doctor-patient treatment decisions, and the Deputy Minister's lack of authority to override professional and parental judgments that such placement served their children's best interests. Deputy Minister Porush had asserted that he acted to protect these individuals with severe retardation from any attempts to proselytize them. The plaintiffs countered that such allegations were baseless, that the residents lacked capacity or interest in religious matters, and that the Deputy Minister was attempting to politicize a professional judgment concerning mental retardation treatment. In view of the severe disabilities of the residents and the informed decision of their parents to place them in a program offering bona fide treatment for mental retardation, the parents' actions appear to be reasonable and entirely legitimate, especially given the 800-person waiting list for residential placement that exists in Israel.¹⁶¹ Indeed, the Deputy Minister's actions have recently been criticized on similar grounds by

160 B. Hutman, "Freed from closed mental ward, youth again refuses chemotherapy", *Jerusalem Post*, 5 June 1991, p. 10. (youth enlisted support of Education Minister Z. Hammer who was prepared to sponsor legislation to prevent forced hospitalization of persons of sound mind, and to intercede with Health and Justice Ministers to find acceptable alternative treatment program).

161 This extensive waiting list has existed for many years. Interview with Yair Gilboa, Director-General of AKIM, in Tel Aviv (7 November 1990).

his resigning Director-General of the Ministry of Labour and Social Affairs.¹⁶² After the litigation had stalled any further attacks by the Deputy Minister and with the Attorney General unwilling to defend the action, the case was quietly settled and the petition dismissed. Unlike the U.S. constitution's separation of church and state, Israeli citizens lack similar legal protection against religious imposition by state agents and must sometimes cope with ministers who appear more attentive to religious agendas and scoring points with their constituencies than to the main tasks of their departments.¹⁶³

Involuntary or non-consensual sterilization also raises troubling legal issues in Israel. Although no law specifically exists governing this matter, such operations have periodically occurred.¹⁶⁴ In 1991, such a procedure was performed on a 40-year-old married woman at the behest of a welfare officer. Acting with the consent of the woman's guardian, the social worker bypassed the interdisciplinary evaluation committee within the Labour and Social Affairs Ministry. He instead invoked the emergency powers of the Welfare (Treatment of the Mentally Retarded) Law, 1969. Under section 16 of this law, the worker proceeded to instruct the hospital to perform the sterilization as a treatment that could not be delayed, afterwards notified the court of his action, and received judicial endorsement after a brief colloquy in court concerning the husband's views on the sterilization of his wife, "Shula".¹⁶⁵ The worker rationalized that there was no time to proceed more cautiously, since he wished to spare Shula an additional anaesthetic procedure (she was already scheduled to deliver her child by caesarean section and could be sterilized during the same surgery). He further asserted that

162 D. Izenberg, "Labor Ministry director quits in row with Porush", *Jerusalem Post*, 1 July 1991, p. 12.

163 See generally N. Cantor, "Religion and State in Israel and the United States" (1988) 8 Tel Aviv U. Studies in Law 185.

164 R. Hegesh, M.D., "Sterilization in Israel", unpublished paper presented at Fifteenth Congress of the International Academy of Law and Mental Health, in Jerusalem (July 1989). See also A. Eser, "Contraception and Abortion in Mentally Handicapped Female Adolescents Under German Law", in *Psychiatry, Law and Ethics*, A. Carmi, S. Schneider & A. Hefez, eds. (1986) 268, at 270 (German Law permits sterilization only on voluntary basis for persons capable of informed consent).

165 23 L.S.I. 144. R. Sa'ar, "The Officer Will Advise and Consent: Law Entitles Welfare Officer to Give Instructions to Perform Sterilization and to Notify the Court Afterwards", *Ha'aretz*, 3 May 1991, p. 4. "Shula" is a fictitious name used in this article to refer to the sterilized woman.

an additional child would lead to strain on the extended family, that alternative birth control methods would be futile, and that the procedure had been explained to Shula who raised no objection.

The use of such an emergency legal procedure raises a host of human rights concerns. First, post-surgical review by a court seems singularly ineffective, given the operation's irreversible nature. Second, any limitation on the fundamental right to procreate certainly demands, in the terminology of the UN Declaration on the Rights of Mentally Retarded Persons, "proper legal safeguards against every form of abuse".¹⁶⁶ The use of summary emergency powers seems incompatible with that standard. In stark contrast, in most jurisdictions of the United States, Canada, and England, an incompetent person cannot be sterilized without prior judicial review and adherence to exacting substantive and procedural safeguards.¹⁶⁷ These safeguards include court-appointed counsel to represent the interests of the supposed incompetent person, the high burden of proof on the operation's proponent to demonstrate its necessity by "clear and convincing" evidence, and receipt by the court of comprehensive medical, social, and psychological evaluations. Many jurisdictions also require specific judicial findings on the individual's best interests, the lack of feasibility of any less drastic contraceptive methods, the absence of foreseeable change in the individual's capacities to become competent to make the decision for herself, and an in-court attempt to ascertain the woman's views.

In "Shula's case", these safeguards were apparently not present. Furthermore, even though she could read and write, neither Shula nor her husband had the opportunity to make their views known to the judge before the procedure. The decision on the merits may have been proper and benevolent, but since no advocate was appointed for Shula, the only version of the facts presented to the court was the welfare officer's report.¹⁶⁸

166 UN, *supra* n. 20, Art. 7.

167 E.g. *Wentzel v. Montgomery County General Hospital*, 293 Md. 685, 447 A.2d 1244 (1982); *Re Eve* [1986] 2 S.C.R. 388; *Re B. (A Minor) (Wardship: Sterilisation)* [1987] 2 All E.R. 206.

168 The welfare officer did, however, obtain a signed statement from the husband after the hearing, dictated by a social work colleague, that expressed satisfaction with the result. Interview with anonymous social worker, Service for the Retarded, Ministry of Labour and Social Affairs, in Jerusalem (3 June 1991). In my opinion, the system's failure to provide legal representation of Shula and her husband before the steriliza-

To avoid recurrence of these risks to human rights, there are several remedial alternatives. The Knesset could legislate, the Ministry could devise clear instructions to its staff, or the judiciary could refuse to approve a section 16 notification under these circumstances. Another alternative under existing law is for the social worker to obtain prior judicial review of a proposed sterilization. The worker can apply to the court for appropriate protective measures under the Capacity and Guardianship (Amendment) Law of 1983 which states that:

Where the application is for a direction to perform surgery or to take any other medical measure, the Court shall not issue the direction unless it is satisfied, on the basis of a medical opinion, that the measure is necessary in order to protect the physical or mental well-being of the minor, legally incompetent person or ward.¹⁶⁹

In the past, Israeli courts have demonstrated a willingness to defend the interests of legally incompetent persons, even against the countervailing interests of their guardians. In a notable case, AKIM petitioned to be substituted as guardian, and prevented a father-guardian from authorizing an operation in which his son-ward would serve as an organ donor for a kidney transplant to the father. The Supreme Court reasoned in *Attorney-General v. X and others* that such a removal of an organ would violate a basic human right of the individual unless done with the individual's express consent or, if incompetent to consent, at the direction of a court based on findings that the operation was necessary for the ward's physical or mental well-being.¹⁷⁰ On the basis of medical opinion, the unanimous court held that these requisite findings under the Capacity and Guardianship Law, 1962¹⁷¹ were not established. In canvassing the relevant Jewish law, Deputy President Elon concluded that protecting the ward's well-being required the guardian

tion, compares unfavourably to practices elsewhere. S. Herr & M. van Melle, "Reproductive Choices: Sterilization, Abortion, and the Rights of Persons with Mental Handicap", in *Workshop Bio-Ethics * Mental Handicap: Report on the European Workshop*, 6-8 November 1989, (The Hartekamp, Heemstede, The Netherlands, Bishop Bekkers Institute, 1992) 62.

169 Capacity and Guardianship (Amendment) Law, 1983, (37 L.S.I. 87) sec. 7, amending Capacity and Guardianship Law, 1962, 16 L.S.I. 106, sec. 68.

170 *Attorney-General v. X & others* (1988) 42(ii) P.D. 661, digested in (1990) 24 Is. L. R. 144-48.

171 *Supra* n. 169, sec. 68(b).

to satisfy the material, social, emotional and medical needs of the legally incompetent person. Organ donation by such a person contravened this principle, unless it promised significant benefit, both physically and emotionally, to him or her.

Courts have also applied criminal sanctions in cases in which parents abandon a disabled newborn in hospital. In one recent controversy, the court convicted a mother for abandoning her infant with Down's Syndrome in a hospital for the first two and one-half months of the child's life. Although the child was ultimately placed in a foster home, the court in *State of Israel v. Hadida*¹⁷² announced that the criminal conviction was intended as a deterrent to the public but suspended the sentence on the condition that the defendant not abandon another child, a rather unlikely circumstance. Despite a similar case in Belinson Hospital, children continue to be abandoned in hospitals. This problem reflects both the tendency of some medical professionals to advise parents not to raise disabled infants at home and the lack of support services to aid families in the child's formative years.¹⁷³

IV. *Taking Disability Rights Seriously*

A. *Assessing the Israeli Experience*

Any evaluation of the Israeli record of protecting the rights of persons with mental disabilities must acknowledge the difficult environment such an enterprise entails. The political establishment and the public alike have given relatively low-priority to such human rights concerns. Governmental funding for special education, treatment, residential care, and other vital services is limited compared to the United States and many Western European nations. The continued need to emphasize military preparedness, as well as the heightened needs for the absorption of new immigrants, leaves little budgetary flexibility especially for minorities who lack strong political links or self-assertion. Without a written constitution or a statutory-based charter of human rights, the

172 Beersheva District Court, 397/88 (4 July 1990).

173 Interviews with Dr. Arik Rimmerman, Senior Lecturer, Bar-Ilan University (5 June 1991) and Nati Kovu, Sub-Chief, Department of State Comptroller, Tel Aviv (31 July 1991).

disabled minority must look to ordinary legislation or the common law for human-rights protection.

Legal reforms in Israel have been difficult to achieve. In the few cases that have emerged to date, the judicial results have tended to be somewhat paternalistic, or have produced narrow settlements rather than broad precedents. Judges may be reluctant to issue sweeping rulings that may have fiscal impacts or encourage other disadvantaged groups to seek comparable relief. Unlike the United States, Australia and Canada, no legislation exists that proscribes discrimination against disabled persons or defines advocacy measures for their benefit.¹⁷⁴ No broad public interest movement exists to employ a legal-rights strategy to advance the status of disabled and other underrepresented interests.¹⁷⁵ Organizations of disabled persons have not formed a self-conscious civil rights lobby or used the courts on a systematic basis.¹⁷⁶

Existing legislation provides different levels of services and benefits, depending on the cause of the disabling condition. By common consensus, disabled veterans receive the most generous benefits and rehabilitation services.¹⁷⁷ This program includes not only monthly disability

174 E.g., Americans With Disabilities Act of 1990, 42 U.S.C.A. §§ 12101-12231 (West Supp. 1992); New South Wales Anti-Discrimination Act 1977, Statutes of New South Wales (amended 1982); Can. Const. (Constitution Act, 1982) pt. 1 (Canadian Charter of Rights and Freedoms), § 15(1). See B. Tucker, "The Americans With Disabilities Act: An Overview" (1989) U. Illinois L. R. 923.

175 For reviews of the U.S. public interest law movement, see N. Aron, *Liberty and Justice For All: Public Interest Law in the 1980s and Beyond* (1989) (diversity of activities in realizing the rights and ensuring the civil liberties of minorities); M. McCann, *Taking Reform Seriously: Perspectives on Public Interest Liberalism* (1986) (activists rely too heavily on legal strategies to the detriment of other approaches to effecting fundamental social change).

176 Interview with Israel Globus, Registrar of Companies & Chairman, The Roof Association of Organizations of Persons with Disabilities, in Jerusalem (30 May 1991). On the contrasting U.S. experience, see H. Davis, *The Civil Rights Era: Origins and Development of National Policy* (1990) 4, 470 ("Interest group lobbying for social regulation probably reached its apotheosis of effectiveness in the mobilizing of the physically handicapped during the 1970s"); *The Supreme Court and Human Rights*, B. Marshall ed., (1982) (willingness of U.S. Supreme Court to decide fundamental human rights claims involving minorities, personal freedom and the right to counsel).

177 Interview with Prof. Avrum Doron, Hebrew University School of Social Work, (18 July 1991). Prof. Doron, a specialist in social security, ranks the level of benefits from war-disabled veterans (highest), hostile-activity disabled persons, road accident victims, work-injured disabled persons, to persons otherwise disabled (lowest). See also U. Procaccia, A. Miller & D. Kretzmer, *The Rights of Disabled Persons in Israel* (Jerusalem, 1977, in Hebrew).

pensions, but the provision of transportation allowances, housing loans, education, vocational rehabilitation, job placement, medical services, adaptive devices, psychological services, and rehabilitation counseling.¹⁷⁸ Civilian victims of hostile acts also enjoy pension and rehabilitation rights. Compared to these disability groups, Israelis otherwise disabled from birth, accident, or illness fare less well.¹⁷⁹

Some Israeli observers maintain that the positive public attitude to the war-disabled carries over to the advantage of all disabled persons. They see an open acceptance of such persons in society, and a high level of social solidarity, benevolence, and even compassion displayed. Few in public life would openly deny that persons with disabilities have rights that must be respected. The public supports private institutions through charitable campaigns, a generosity that permits some islands of excellence in services to persons with developmental disabilities.¹⁸⁰ Recently consumer groups and some professionals have taken steps to publicize the need to reshape the over-institutionalized systems of care.¹⁸¹ In general, the problem is not one of antipathy to persons with mental disabilities, but of limited public awareness of their rights and needs.

B. *The Case for Human Rights Initiatives*

Without a systematic human rights campaign, it is unlikely that the rights of Israelis with mental disabilities to treatment, habilitation, education and personal liberty will enjoy higher priority in the near

178 Israel Ministry of Defence, Department of Rehabilitation, *Rehabilitation Programs and Benefits for Disabled Veterans and Families of Fallen Soldiers* (October 1986) 4.

179 On the difficulties that Israelis with physical disabilities have in claiming their support benefits, see Israel State Comptroller, *41st Annual Report* (1991) 636 (out of 998 physically disabled persons needing and eligible for care, only 130 received special support under National Insurance Institute regulations for work-related impairments).

180 E.g., Beit Isadore Shapiro in Ra'anana (comprehensive day programs for children); AKIM Haifa (supported apartment living programs); AKIM Hadera (group home complex). See L. Levavi, "Akim to seek NIS 3m. for its activities", *Jerusalem Post*, 21 April 1991, p. 2.

181 For example, the Conference on Closed Institutions and the Alternatives, Van Leer Institute, in Jerusalem (3 June 1991) presented a number of such views.

future. There are several possible explanations why the status quo endures and why new initiatives are needed to alter it. Parents and professionals report a widespread fear among parents that litigation or other vigorous advocacy on behalf of a disabled family member will lead to victimization of the person with the disability or dismissal of the complainant as a troublemaker. Other parents and organizations believe that their "proteksia" (string-pulling) and negotiating skills are so successful that they can avoid confrontation and human rights approaches. Some parents may be willing to speak out to improve institution conditions, but are so grateful that the burdens of care have been lifted from their shoulders and that the worries of community living are avoided, or feel that a closed institution is good enough, that they do not press for community care.¹⁸² Other organizations are sensitive to the risk of ruptured relationships with the very agencies they depend on for funding, ministerial-authorized staff positions, licensure, and the like. Special interest groups may also feel constraints as citizens of a besieged and financially-strapped democracy from pressing their parochial claims too vociferously. Thus, advocacy by family members and special interest groups has often been muted for a variety of reasons.¹⁸³

Direct advocacy by persons with mental disabilities has also been infrequent for self-evident reasons. Some persons have cognitive or emotional impairments that limit their ability to identify injustices as human rights matters, to communicate such concerns to those in authority, to gain the attention of influential outsiders (e.g., journalists, lawyers, state comptroller staff), or to advocate for themselves. In Israel, unlike England, Scandinavia and the United States, there is virtually no organized self-advocacy movement.¹⁸⁴

182 Anonymous, social worker in large mental retardation institution (11 July 1991).

183 The social stigma still associated with mental illness or mental retardation can inhibit robust advocacy. Some families may also be unassertive, unaware of their legal rights, preoccupied with daily problems, dependent on the good will of public officials, and/or lack the money, time or knowledge to consult a lawyer. Interview with Zorach Rosenblum, *supra* n. 73.

184 Although there have been some organizations of ex-mental patients, self-advocacy groups organized by people with mental retardation with the help of advisors do not exist in Israel. On the value of self-advocacy to build positive images of such persons, see A. Shearer, *Think Positive! Advice on Presenting People with Mental Handicap* (International League of Societies for Persons with Mental Handicap, 1984) 23-24.

Compared to other developed countries, advocacy on behalf of disabled persons is also weak and sporadic.¹⁸⁵ Instances in which cases reach the courts are largely cases in which organizational interests are affected, articulate individuals resist a disability label, or some third-party prompts the disabled person (or his or her representative) to come forward with a complaint.

The legal profession has done little to improve such persons' access to justice. *Pro bono publico* legal services are still rare. Under statute and bar association rules, a lawyer must first notify the bar before accepting a case in which a fee is waived.¹⁸⁶ Law students, unlike their counterparts in the United States, have few opportunities to receive classroom or clinical instruction in this field.¹⁸⁷ Traditional ethical rules barring advertising and solicitation of clients may also inhibit reaching out to prospective clients who need information or other assistance in exercising their rights. At present, there is little incentive for lawyers

185 R. Kramer, *supra* n. 9, at xxi (comparing Israel, Netherlands, England and U.S. voluntary agencies serving disabled persons, and concluding that Israel can learn from others about strategies for citizen participation and advocacy and other countries from Israeli efforts at equitable distribution of resources). On the Psychiatric Patient Advocate Office created pursuant to the Ontario Mental Health Act, 1980, § 5, see S. Atkinson, M. Madill, D. Solberg, & T. Turner, "Mental Health Advocacy: Paradigm or Panacea?" (September 1985) *Canada's Mental Health* 3.

186 The Chamber of Advocates Law, 1961 (15 L.S.I. 196), sec. 81 states, in pertinent part, that: "Where the tariff lays down a minimum fee for a particular service, an advocate shall not stipulate or accept a lower fee save with the permission of the District Board given in respect of a particular matter or class of matters; Provided that an advocate may render a service free of charge if he notifies the fact to the District Board by reasoned notification". Such notification is a relatively routine matter and the rule is designed to protect against unfair competition rather than to discourage *pro bono* service. Interview with Professor Dan Shnit, Tel Aviv (4 June 1991).

187 For exceptions, note Prof. Shnit's class on the rights of children, the mentally ill, and the mentally retarded, and Dr. Kenneth Mann's criminal law clinic (which has included cases of mentally disabled defendants), both at Tel Aviv University Faculty of Law. However, clinics still encounter a degree of resistance from some sectors of the bar association to law schools providing client representation. Furthermore, unlike their U.S. counterparts, Israeli law students do not have the right to appear in court under a rule permitting student practice in approved programs of clinical legal education. However, clinics in Israel are developing, with a civil law clinic operating for several years at the Hebrew University Faculty of Law, and the new Center for Legal Aid in Criminal Cases expected to open branches in the Tel Aviv and Jerusalem universities.

to specialize in this field and become experts, not only in the law, but the subject matter of the professional field itself.

Independent officials only sporadically publicize human rights complaints in this field. Although the office of the State Comptroller has jurisdiction over the public agencies that provide care, it has not directed systematic attention to the human rights problems of the mentally disabled.¹⁸⁸ Its critical study in 1988 noting failures to perform periodic re-evaluations did not lead to wider investigations or to effective remedial measures.¹⁸⁹ In 1991, the State Comptroller's annual report criticized policies requiring mental patients to come to hospitals for out-patient care when community-based clinics were the preferred treatment site.¹⁹⁰ However, the latest report is silent on mental retardation services and lacks focus on either individual human rights or broader mental health policy directions.

Members of the Knesset could also be more active as guardians of disability rights through the powers to question ministers, to conduct oversight hearings, and to propose private legislation. In one innovative exercise, eight Members of Knesset recently conducted surprise inspec-

188 The ombudsman offers the dependent client the advantage of a free service that assumes the burden of factual investigation and case presentation, but the client has no control over the case's handling and remedy. J. Handler, *supra* n. 85, at 89-95, 145. On the activist role of the Swedish ombudsman in this field, see S. Herr, "Rights into Action: Protecting Human Rights of the Mentally Handicapped" (1977) 26 Catholic U. L. R. 203, at 237-241. On the limitations and achievements of the Israeli equivalent of the ombudsman, see C. Aharoni, "Activities of the State Comptroller Regarding the Care for the Retarded (1966-72)", in C. Aharoni, *Not Exactly As Everybody* (1989) 107 (no review of private institutions or proactive activity in field).

189 See *supra* n. 111 and accompanying text. For earlier critical reports on mental retardation services, see Israel State Comptroller, *31st Annual Report* (1981) 454-466 ("a considerable number of individuals with mild or medium retardation who can function in the community" are retained in institutions because of shortage of hostels and special apartments, *ibid.*, at 459; 423 persons on waiting lists for institutions; government continues to send individuals to unlicensed private institutions; in 52 of 66 cases the welfare officer notified of individual's mental retardation only after at least a year's delay; further delays in decisions by diagnostic evaluation committees, even for a pre-trial detainee held for ten months awaiting such a decision) & *36th Annual Report* (1986) 656-666 (lack of standards for payment of worker-residents, and no social worker or psychiatrist on residential staff). On grievance mechanisms for individuals, see M. Ramon, "Handling of Complaints in Health Systems in the U.S.A., Canada, England and Israel", in *Hospital Law*, A. Carmi & S. Schneider, eds., (1988) 123.

190 Israel State Comptroller, *41st Annual Report* (1991) 409-423.

tions of mental retardation institutions, and reported their findings at a public forum.¹⁹¹ These members could provide the core of an all-party parliamentary lobby for mental disability services, focusing more attention on the problems of lack of community care and ensuring that any savings in institutional costs are redirected to alternative community services rather than elsewhere in the budget.¹⁹² Some M.K.s also recognize the importance of supporting appeals of persons with mental disabilities to the Supreme Court; exposing human rights problems in the media; and the formation of a strong, well-coordinated advocacy coalition to bring pressure to bear upon the Knesset's finance committee, the government and the various political parties to address disability issues more forcefully.¹⁹³

Significant reform action, however, is likely to require a well-prepared study of existing legislation, standards and practice, as well as the development of a strong advocacy movement. A litigation-based campaign can be an important feature of that movement since the welfare state is not necessarily sensitive to human rights values unless those values are vigilantly defended.¹⁹⁴ Overhaul of outdated statutes and the implementation of modern entitlement-based laws can, even in the absence of a codified bill of rights, address many of the human rights

191 Given their low expectations of what they would find and lack of training in identifying violations of professional standards in such institutions, the M.K.'s reports focused on the physical conditions of the buildings they observed and produced only anecdotal information. Conference on Closed Institutions and the Alternatives, Van Leer Institute, Jerusalem (3 June 1991).

192 Interview with Yair Tsaban, Member of Knesset, in Tel Aviv (7 August 1991). He proposes that since government institutions are almost twice as expensive to run as private ones that the government transfer them to non-profit organizations and use the savings to operate new community-based living arrangements. For a cautionary note on privatization of welfare services, see J. Katan, "Voluntary Organizations — A Substitute for or a Partner to State Activity in the Social Arena" (1990) 2 Social Security: J. Welfare and Social Security Studies (Special English Edition) 134.

193 Tsaban interview, *supra* n. 192. One proposed case in which M.K.s may sue involves a kibbutznik who is alleged to be confined in a mental hospital despite his mental retardation and lack of mental illness.

194 As one senior social worker expressed it, his Ministry is "afraid of *Begatz*" [Israel's Supreme Court] and would do all in its power to avoid legal judgment by settling individual cases, thus "the minute you go to *Begatz*, you find a place" for the person with mental retardation. To avoid problems of mootness in the face of such a response, lawyers would have to devise strategies of filing successive claims or seeking group remedies.

of persons with mental disabilities.¹⁹⁵ Statutory reform alone will prove inadequate, if accompanying changes in regulations, policies, and professional practices are not made to turn symbolic rights into realities. For example, the Treatment of Mentally Sick Persons Law, 1991 is reported as having little practical effect in its early stages of implementation, as professionals felt little need to change their modes of practice.¹⁹⁶ Furthermore, some experienced observers are skeptical that officials will properly implement any policy of deinstitutionalization, but will instead use such a policy as an excuse to close costly institutions and "dump" their clients.¹⁹⁷ In this climate of mistrust and weak implementation of the law,¹⁹⁸ advocacy coalitions and offices are essential as a check and balance on the bureaucracy and politicians absorbed with other priorities. In this enterprise, the social work and legal professions, sharing comparable value systems on the dignity of the individual, can act to protect persons with disabilities from all forms of abuse and denial of their human rights. As this article has suggested, they can draw inspiration from international declarations that provide a common frame-

195 One of the less visible human rights issues pertains to the administration of guardianship laws. Although an estimated 80% of the 4200 adults in mental retardation institutions are under guardianship, such individuals never appear in court, are not consulted on the choice of a guardian even when capable of expressing a view, have no advocate to present their position in the appointment process, and rarely obtain reevaluation or review of their status. Another low-visibility issue is the failure to either supply professionally recommended therapies or to do so too infrequently. Interview with anonymous social workers, in Ra'anana (11 July 1991). Yet after a parent of a resident requiring physiotherapy two hours daily, but receiving it only two hours weekly, threatened to go to the Supreme Court to avoid the resident's further deterioration and informed the Ministry of this intention (through AKIM), the daily services were provided. Interview with anonymous social worker (8 August 1991).

196 See Interview with Dr. M. Zohar, District Psychiatrist, Abarbanel Hospital, Bat Yam (19 June 1991) (committee review expected only in new cases rather than in every involuntary case as mandated by law; dangerousness standard applied as exclusive grounds for committal since low awareness of new standards; tendency to scrutinize new cases and rely on files in old ones).

197 Interviews with Kadman and Doron, *supra* nn. 68 & 177.

198 Interviews with A. G., and D. H., social workers (5 June 1991) noting that institutional staff fear to speak out and parents fear to "make waves" since parents who complain about substandard conditions may receive letters threatening to release or discharge their children from institutions; and that nonretarded or borderline retarded persons who could move out immediately are retained.

work for action and a measuring stick for reforming the applicable domestic law.

An important step in advancing the state of human rights for persons with mental disabilities in Israel could be the creation of a specialist advocacy office (AO) for persons with mental disabilities. The AO could be staffed by lawyers, social workers and other advocates.¹⁹⁹ The value of advocacy is well-recognized internationally as a way of advancing the interests of individuals and groups of persons with developmental disabilities, and of protecting their human and legal rights.²⁰⁰ Israeli society also recognizes the need for strong advocacy for this vulnerable and under-represented minority.

One form of this advocacy focuses on casework for individuals. Individuals with disabilities and their families may have acute problems in claiming their rights and benefits under existing laws. For example, the State Comptroller in her 1991 report cites many instances of disabled children and adults who lacked information on their rights,²⁰¹ or assistance in claiming benefits due,²⁰² or timely payment,²⁰³ or any compen-

199 To limit initially such an advocacy office's mission to the mentally disabled (mentally ill and mentally retarded) or to a subset such as the developmentally disabled, is not to denigrate the equally pressing advocacy needs of other worthy groups such as persons with physical disabilities. Such a decision instead reflects pragmatic limitations on the scope of service that a small specialist office can offer at first, and the possibilities that other potential clients can use generic advocacy resources.

200 International League of Societies for Persons with Mental Handicap, *Advocacy and Mental Handicap* (ILSMH position paper officially adopted October 1984); ILSMH, *Step By Step: Implementation of the Rights of Mentally Retarded Persons* (1978) 22, at 29; S. Herr, *Rights and Advocacy for Retarded People* (1983) 211-236; R. Kurtz, *Social Aspects of Mental Retardation* (1977) 145-49; J. Simpson, "The Role of a Specialist Rights Service in Protecting the Rights of People with Intellectual Disabilities", in *Australian Society for the Study of Intellectual Disability Newsletter* (August 1986) 32; Developmental Disabilities Assistance and Bill of Rights Act of 1990, 42 U.S.C.A. §§ 6000(b)(4), 6041-6043 (West Supp. 1991). On the value of rights-oriented approaches, see R. Dworkin, *Taking Rights Seriously* (1977).

201 Israel State Comptroller, *41st Annual Report* (1991) 637-38 (special services to disabled persons living alone underused since procedures for claiming such benefits not published and intended beneficiaries lack information or anyone to act for them).

202 *Ibid.*, at 635-36 (criticizing National Insurance Institute for lack of outreach or other assistance to enable severely retarded persons to exercise their right to special services even though Institute had data to locate them or their representatives).

203 *Ibid.*, (surveying 187 cases of severely retarded persons with IQ 39 or lower and finding that only 36% of their families timely applied for special services; others applied from two to ten years after regulations went into effect).

sation for delay in receiving benefits.²⁰⁴ Without advocacy assistance and monitoring on an individual and group basis, it is unlikely that the intended beneficiaries will overcome bureaucratic obstacles to the timely enjoyment of their rights.²⁰⁵

Although a variety of groups engage in such advocacy from time-to-time, no single organization provides full-time advocacy services in a comprehensive, coordinated and sustained way. These services should be available to the full range of persons with cerebral palsy, mental retardation, autism, organic brain damage, and other developmental disabilities. Such an advocacy office would ideally provide:

1. monitoring and publicity concerning the degree of compliance with existing laws and human rights norms;
2. legal assistance to individuals and groups;
3. casework, assessment of service needs, and negotiation;
4. reform of legislation, regulations, and guidelines;
5. other creative advocacy and public education strategies.

204 *Ibid.*, at 632. The State Comptroller also criticized the disabled children's benefits program on the grounds that 4000 eligible children receive no benefits, others face delays in payment, others are improperly assessed, consistent national standards are lacking, and the intended beneficiaries do not receive help to exercise their rights in a timely way. *Ibid.*, at 655-57.

205 Advocates are also needed to assist in the exercise of non-monetary rights. For example, ACRI investigated and resolved a complaint in 1991 that the marriage plans of a slightly retarded woman were blocked by an evaluation committee of the State Mental Retardation Service claiming to act under their Section 7 power of the Welfare (Treatment of Retarded Persons) Law to prescribe "modes of treatment". Interview with Neta Ziv Goldman, Director, Litigation Center of ACRI (7 August 1991). ACRI questioned whether the committee was acting outside its authority and whether the status of getting married can be deemed a form of treatment subject to this law. After the woman's family threatened to go to court, the woman was evaluated by a world-famous specialist in mental retardation, who recommended that the woman receive some training and assistance before marriage. Unfortunately the prospective husband became greatly discouraged by these interventions and the marriage plans were cancelled. Almost a year later, the woman's local social worker requested that the evaluation committee lift its order preventing the woman from registering to marry. When the committee refused to cancel its order, ACRI filed an administrative appeal on behalf of the social worker and the woman, scheduled to be heard in late September 1992. Letter from Neta Ziv Goldman to Stanley S. Herr (23 July 1992).

This broad concept of advocacy finds support in the position paper of the International League of Societies for Persons with Mental Handicap, which defines advocacy as "the process of pleading the cause and/or acting on behalf of persons with mental handicap to secure the services that they require and the enjoyment of their full rights. . . . As agents of persons with mental handicap, [advocates] owe them a duty of loyalty, confidentiality, and a commitment to be zealous in promoting their cause".²⁰⁶ Due to cognitive or emotional limitations or dependence on others, such persons often have great difficulty exercising their rights or claiming their benefits in a timely manner.²⁰⁷ Clients in institutions face special risks, as they may lack the means to seek a remedy or face retaliation for asserting a right.²⁰⁸

Properly structured and funded, an advocacy office can combine both national law reform with locally-focused case advocacy functions for children and adults.²⁰⁹ These two functions are compatible provided that the office devotes a major proportion of its resources to advocacy before central agencies (for example, the Knesset, the relevant ministries, and the courts in potentially precedent-setting cases), while being selective in the volume of individual service cases. Through this latter case advocacy in a major population center, the advocacy office would be able to 1) select subject matters of recurrent interest and importance, 2) uncover local problems of implementation, 3) identify problems requiring national strategies and resources, and 4) provide direct and immediate services to persons with disabilities and their families. Examples of such subject matters for advocacy include special education, reducing waiting lists for community and other residential services, rights in residential facilities, freedom from discrimination and abuse, and protection of human dignity and liberty. Organizational options exist to

206 International League of Societies for Persons with Mental Handicap, *supra* n. 200, at 3.

207 See nn. 200-205, *supra*.

208 J. Handler, *supra* n. 85, at 69: "In general, it is very difficult for a client to exercise his legal rights when he is faced with institutional adversaries who exercise discretionary authority over the things he needs and wants. For the institutionalized client who is fighting the institution, such a challenge is almost impossible".

209 For a proposal for such an office that identifies potential funding sources, see S. Herr, "Concept Paper on Advocacy for Persons with Developmental Disabilities in Israel" (May 1991, unpublished paper on file with ACRI, AKIM, & the National Council for the Child).

create such an advocacy office on an expedited basis.²¹⁰ The office would need a priority-setting process to set a proper balance and sequence of advocacy objectives.²¹¹

In addition to external advocacy, influential committees and academic researchers can frame recommendations that strengthen human rights protections. Clear and forceful recommendations by the Shnit Committee could lead to a thorough overhaul of the Welfare (Treatment of Retarded Persons) Law, 1969 and its replacement by a developmental disabilities law.²¹² A new law could stress integration and coordination with other laws and services to support the full continuum of services,

210 One option is to form a specialized unit within an already established advocacy service provider in the civil liberties, disabilities or related fields. The second is to create a "free-standing" new office in the manner of the National Council for the Child in Jerusalem. The third is the consortium approach in which several organizations jointly sponsor the new advocacy office. In the Israeli environment, options one and two may have the greatest appeal and likelihood of smooth functioning. Option one has the additional advantage of the shortest "start-up" time, while not precluding the entity from becoming fully independent in the near future. For example, the Mental Health Law Project in Washington was initially a part of the Center for Law and Social Policy (a wide-ranging public interest law office) until the Project gained the prestige and financial stability to stand on its own.

211 For example, the office would have to define its mission in terms of population served (persons with mental retardation, or progressively wider subsets of persons with developmental disabilities, or persons with mental disabilities) and methods of advocacy emphasized. In the likely event of scarce resources, it might give priority to reform of national law and public policy in order to maximize the number of disabled persons benefitted. On the U.S. legal requirement of setting objectives and priorities in governmentally funded advocacy programs for persons with developmental disabilities, see 42 U.S.C.A. § 6042(a)(2)(C) (West Supp. 1991).

In 1992, ACRI expects to open a subsidiary, independent organization (with its own separate board, budget and advisory committee) that would initially defend the rights of persons with developmental disabilities. The organization will be named "Bezchut", which can be translated into English as "With the Right". Letter from Neta Ziv Goldman, *supra* n. 205. This new organization is expected to concentrate on intervention with the authorities to implement or modify rights and policies, as well as on litigation, legislation and public education.

212 23 L.S.I. 144. For definitions of that broader disability category and examples of such laws, see Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C.A. §§ 6001(5), 6000-6083 (West Supp. 1991) (such individuals have a severe, chronic impairment, occurring prior to age 22, which results in substantial limitations on areas of major life activity such as learning and capacity for independent living); Developmental Disabilities Law, Md. Code Health-General Ann. §§ 7-101 *et seq.* (1990 & Supp. 1991). On the Shnit Committee, see *supra* n. 6.

rather than reliance on outmoded forms of highly segregated care. Although the prospects of a clear entitlement to such developmental services are cloudy, there are some precedents. The Long-Term Care Insurance Law,²¹³ for example, entitles certain disabled elderly persons to personal long-term care services to sustain their living in the community.²¹⁴ In addition, education law in general and the Special Education Law, in particular, mandates services for school-aged children with disabilities.²¹⁵

The Shnit Committee report could be complemented by independent research projects. Scholarly socio-legal studies are needed to assess how the rights of persons with mental disabilities are protected under the new mental health law and the now two-decades old mental retardation law. Lessons drawn from the reform of mental health law can help to avoid pitfalls in attempts to change mental retardation law and professional practice. A series of narrowly focused comparative law studies between Israel, the United States, and selected countries in Europe could also identify alternative approaches to balancing disability rights with social welfare needs.²¹⁶

213 The National Insurance (Amendment No. 61) Law, 1986, *S.H.* 1178, p. 154.

214 For discussion of this law's scope and potential, see D. Shnit, "The Long-Term Care Insurance Law — The Legal Aspect", (June 1988) *Social Security: Journal of Welfare and Social Security Studies* 84. See also Special English Issue: "Towards the Implementation of the Long-Term Care Insurance Law in Israel", *ibid.*, 1-203 and for an unofficial translation of the law, *ibid.*, 196-203.

215 See Section III. B., *supra*.

216 E.g., On laws to mandate community living arrangements, see S. Brakel, J. Parry & B. Weiner, *supra* n. 120, at 340 (25 U.S. states have statutory requirements for habilitation and normalization that support the trend to small-group living arrangements that are closer to normal environments). On rights to non-discrimination in employment and incentives to encourage employment opportunities, see Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988); International League of Societies for Persons with Mental Handicap, *Work Opportunities for People with Mental Handicap* (1990). For example, the American With Disabilities Act will affect an estimated five million businesses, including doctors and lawyer offices. 42 U.S.C.A. § 12181(7)(F) (West Supp. 1991). These commercial establishments will be subject to regulations described by Attorney General Thornburgh as striking "a balance between the rights of persons with disabilities to enter the mainstream of society and the workplace, and the financial and physical limits of the business community". S. Holmes, "U.S. Rules Would Force Businesses to Make Alterations for the Disabled", *N.Y. Times*, 22 February 1991, p. 10.

The critical question is whether the political will to change the status quo in mental disability services can be mustered. As one commentator suggests, the prevailing system serves the convenience of the centralized state bureaucracy and the treatment professionals who have maximized their discretion and autonomy, often at the expense of clients' rights.²¹⁷ These professionals, as well as the statutory committees that ostensibly review their decisions, often tend to see the law and concepts of clients' rights as largely irrelevant to their work.²¹⁸ However, an alliance between articulate consumers, frustrated parents and guardians, professional advocates, reform-minded academics and professionals can change this consciousness. Such an alliance could also help to create a human rights movement for persons with disabilities in general and for persons with developmental disabilities in particular.²¹⁹ Some charismatic personalities may be needed to act as catalysts for change, using their leadership as the social theorist Max Weber suggested, to unsettle bureaucracies hostile to innovation.²²⁰ While in the United States federal judges have sometimes performed some of the charismatic leader's functions and broken conditions of stasis,²²¹ it is unlikely that even the innovative Israel Supreme Court will seek or have the same impact on the developmental disabilities field. Yet, a few early and well-publicized human rights successes in the courts could change a prevailing climate of pessimism and the often glib dismissal of overseas

217 See U. Aviram, "Care or Convenience? On the Medical-Bureaucratic Model of Commitment of the Mentally Ill" (1990) 13 *Inter. J. L. & Psychiatry* 163.

218 Interviews with Joel Levi, lecturer in Tel Aviv University School of Social Work and attorney (22 May 1991), criticizing statutory mental retardation committees as engaging in casual and biased decision making, and with senior psychiatrists (19 June 1991).

219 Interview with Pinhas Noivert, Committee on Accessibility, Jerusalem (18 June 1991). On the effective coalitions between lay and legal advocates in the United States, see R. Kurtz, *supra* n. 200, at 148.

220 M. Weber, *On Charisma and Institution Building*, S. N. Eisenstadt ed., with an introduction (1968). On bureaucracy and its depersonalizing effects, see M. Weber, *The Theory of Social and Economic Organizations* (1947 ed.). Some Israeli observers believe that the highly centralized bureaucracies regulating mental disability care are reluctant to change.

221 D. Rothman & S. Rothman, *supra* n. 122, at 355.

experience as irrelevant to reform in Israel.²²² Lawyers in Israel can champion the rights of the mentally disabled and foster "legitimate and major social change" on their behalf as they have for other disadvantaged groups.²²³

Legal change *per se* may have only limited impact on safeguarding human rights of persons with mental disabilities. More systematic training of social workers, medical practitioners and other rehabilitation professionals seems vital if they are to understand and defend their clients' human and legal rights. Such training is desirable at both university and in-service levels.²²⁴ Finally, parents and disabled persons require accessible information and basic training to become more assertive and confident advocates of their own causes.²²⁵ An informed citizenry can then shoulder some of the concrete responsibilities of preventing rights violations instead of relying on uncertain *post facto* remedies.²²⁶

V. Conclusion

The symbolism and practical effects of rights for mental patients or persons with mental retardation can foster recognition of their dignity as human beings. This recognition can boost political support for their

222 On the use of the courts to advance equality rights in the context of gender bias, see *Nevo v. National Labour Court* (1990) 44(iv) P.D. 749 (holding that different retirement ages for men and women constitutes impermissible discrimination: "When the court confronts a situation of distinction between groups, it must scrutinize meticulously whether that distinction is founded on generalized stereotypes based solely on prejudice": per Bach, J.) See also, D. Izenberg, "One Step Nearer Equality", *Jerusalem Post*, 26 Oct. 1990, p. 8, col. 4 (interview with Prof. Frances Raday, predicting that favourable precedent and Equal Retirement Age for Men and Women Law, 1987 (S.H. 1208, p. 48) will encourage women to seek judicial remedies for economic discrimination).

223 See R. Kurtz, *supra* n. 200, at 149.

224 Some psychiatrists, for instance, report that their university training offered them little instruction on patients' rights and left them with the impression that mental health treatment and human rights were in irreconcilable conflict.

225 See S. Herr, *Issues in Human Rights: A Guide for Parents, Professionals, Policymakers and All Those Who Are Concerned About the Rights of Mentally Retarded and Developmentally Disabled People* (1984); National Insurance Institute, *The Rights of Handicapped Persons: A Manual* (1991, Hebrew).

226 See R. West, "The Supreme Court, 1989 Term — Foreword: Taking Freedom Seriously" (1990) 104 Harv. L. R. 43.

improved services, civil liberties and affirmative legislative relief. The Shnit Committee, for example, could recommend that Israeli laws on the rights to education, habilitation, and other community services be more forcefully defined and implemented, casting some rights in terms of entitlements rather than aspirations.²²⁷ New human rights standards could thereby protect disabled persons from discrimination or arbitrary decision, and shift the burden of persuasion to the government when services to eligible persons are delayed or denied.

This article has revealed some deficiencies in existing human rights protection for persons with mental disabilities and the need for effective means of redress. Rights which are not taken seriously can undermine the status of a minority. Although other disadvantaged groups in Israeli society (such as persons with serious physical disabilities, troubled children and infirm elders) might also benefit from similar human rights initiatives, they tend to suffer less stigma and less institutional isolation, enjoying greater legal protection than Israeli citizens with mental disabilities.²²⁸ This article has therefore proposed strengthening the legal and human rights safeguards for this vulnerable group through methods such as advocacy, public education, research, and legislation.

While no country has fully protected the rights of persons with mental disabilities, international human rights standards and campaigns to realize them have had salutary effects on services as well as on public consciousness. In the United States, Canada, Australia and parts of Europe, legal changes have led to fairer procedures, gains in access to community services, and tangible recognition of the human dignity of individuals with disabilities. Coupled with new human rights initiatives, Israel's commitments to "freedom, justice and peace as envisaged by the prophets"²²⁹ can offer its citizens comparable rights and advantages.

227 The Shnit Committee is expected to report its conclusions in 1993. See n. 6, *supra*.

228 On children's rights, see Israel Ministry of Labour and Social Affairs, *Selected Israeli Laws Concerning Children and Youth* (Dept. of International Relations, February 1991); In the Matter of *A.B. v. C.D.*, C.A. 2620/90, *Jerusalem Post*, 10 June 1991, p. 5 (in custody dispute, child should not be moved to a new environment without the court first receiving assessments and full reports on whether the move was in the child's best interests, and without the child being properly prepared for the move by child care experts). On legal protection for the elderly, see *An Aging World: Dilemmas and Challenges for Law and Social Policy*, J. Eekelaar & D. Pearl, eds. (1989) 317-477 and nn. 17 & 214 *supra*.

229 Declaration of the Establishment of the State of Israel, 1 L.S.I. 4.