 ISSN 2083-0947 / ISSN (ONLINE) 2657-6058
DOI: 10.26881/ae.2017.14.07

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The rights of persons with intellectual disability in the light of European and Polish legislation[1]

Article 32 of the Constitution of the Republic of Poland of 2 April 1997 (*Dziennik Ustaw* of 1997 No. 78, It. 483, as amended) states that "All persons shall be equal before the law. All persons shall have the right to equal treatment by public authorities". As to Polish legislation dedicated to persons with intellectual disability or mental disorders, who are the subject matter of this paper, it includes some articles from the criminal, civil, family and guardianship codes, as well as the act on the protection of mental health, the act on vocational and social rehabilitation and employment of persons with disabilities, and the Charter of Rights of Persons with Disabilities. The related EU legislation includes the Declaration on the Rights of Disabled Persons, and European Social Charter. As can be assumed, their main objectives include the improvement of the rights of persons with various disabilities and ensuring their safety, guaranteeing them the necessary funding (ill health and retirement pensions) as well as treatment and care (residential homes, psychiatric hospitals).

Preliminary results of the 2011 National Population Census concerning the population of disabled persons show that 4,697,500 persons, i.e. 12.2% of the entire Polish population, declared their limited ability to perform ordinary basic activities relevant for their age and/or held a valid certificate classifying them as members of the disabled population. Interestingly, in connection with the voluntary nature of the questions concerning disability, almost 1.5 million respondents refused to give their answers. We may guess that some disabled individuals could also be among them (*Wstępne wyniki z Narodowego Spisu Powszechnego…* [Preliminary Results of…] 2011).

Summing up, the groups of persons whose rights are the subject of my research interest in this article constitute a considerable share of the Polish population –

[1] The legal state as at 26 July 2017.

therefore, it seems so important to discuss the topic. This paper seeks to analyse and discuss the articles, acts, and EU legislation mentioned above, which directly concern persons with disabilities and persons with mental disorders.

Place of persons with intellectual disability in the European Union – anti-discrimination law

From the point of view of human and civilizational development, the end of the 19th century and the first half of the 20th century was a discredited period in history. The development of pseudo-science – eugenics, the two world wars, as well as revolutions and conflicts all over the world – disgraced the essence of humanity due to refined manners of torturing and killing people. After the end of the Second World War, the United Nations adopted the Charter of the United Nations, calling upon all nations to respect human rights, in particular underlining the right to freedom regardless of gender, language, race, and religion (Andrzejuk 2004: 41). The document, ratified by all the countries which experienced losses during the war, has a significant symbolical meaning, although it fails to mention persons with a disability. Beata Cytowska reflects that this fact can be interpreted in two ways: "either the subjects were considered of little importance for the population or/and they were treated like any other person, without identification or stigmatisation of this particular social group" (Cytowska 2012: 134).

The General Assembly of the United Nations took another step on 10 December 1948, drawing up the Universal Declaration of Human Rights. The document contains the first anti-discrimination provision: "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood" (Sokołowski 2004: 12). The act prescribes that differences resulting from race, colour, sex, language, religion, opinion (political or other), national or social origin, property, or birth should be disregarded (Piechowiak 1999: 89).

In the 1950s, 1960s, and 1970s, the General Assembly of the United Nations announced subsequent anti-discrimination acts: the Convention concerning Discrimination in Respect of Employment and Occupation adopted by the International Labour Organisation in 1958,the Convention Against Discrimination in Education adopted in 1960 by the United Nations Educational, Scientific and Cultural Organization, the Convention on the Elimination of All Forms of Racial Discrimination of 1966, and the Convention on the Elimination of all Forms of Discrimination Against Women of 1979. Poland has signed all the above-mentioned documents (Cytowska 2012: 135). The situation of persons with intellectual disabilities and persons with other disabilities was given recognition as late as in the 1970s. Bernadeta Szczupał concluded that this became possible owing to a shift in the understanding of disability from the medical to the social model, mainly in

West European countries (Szczupał 2009: 80). 1971 witnessed the adoption of the Declaration on the Rights of Mentally Retarded Persons, while 1975 – the Declaration on the Rights of Disabled Persons. The former determines the persons' rights to "proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential", "economic security and […] a decent standard of living", the right "to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities", and to "live with his own family or with foster parents and participate in different forms of community life. […] If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life", the right to have "a qualified guardian", and the right to "protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility" (Declaration on the Rights of Mentally Retarded Persons adopted by the General Assembly of the United Nations Organisation under resolution 2856 (XXVI) on 9 December 1975).Both the declarations mentioned above stress that persons with a disability have the same rights as other human beings of the same age, regardless of the degree or type of disability, and should be protected against all forms of abuse and discriminatory or humiliating treatment.

A Decade of Disabled Persons was announced for the period between 1983 and 1992. During that period, organisations and governments were obliged to implement the World Programme of Action Concerning Disabled Persons adopted by the UN in 1982. The programme was an effect of the celebration of the International Year of Disabled Persons in 1981. Towards the end of the 1980s, the UN announced the 3rd of December as the International Day of People with Disabilities, with a view to making society aware of problems related to disability and to promote actions supporting this social group and their active participation (Cytowska 2012: 136). It was only in the Convention on the Rights of the Child adopted by the General Assembly of the United Nations on 20 November 1989 (*Dziennik Ustaw* of 1991, No. 120, It. 526) (hereinafter: Convention on the Rights of the Child) that the need to protect children with intellectual disability was recognised. In Art. 23 of the Convention on the Rights of the Child we can read: "States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community." Poland signed the Convention on 7 May 1991 (Cytowska 2012: 137).

In 1997, the Sejm of the Republic of Poland adopted the Charter of Rights of Persons with Disabilities, in which the Government of the Polish Republic and the local governments are urged to take action aimed at the implementation of these rights. The document includes the following text: "[…] persons, whose physical, psychic or mental ability permanently or temporarily hampers, limits, or makes im-

possible daily life, learning, work and fulfilment of social roles in compliance with legal and customary standards, have the right to an independent, self-governing and active life and must not be subject to discrimination" (Resolution of the Sejm of the Republic of Poland of 1 August 1997 – Charter of Rights of Persons with Disabilities, MONITOR POLSKI No. 50, It. 475). The Polish Government was obliged to inform the Parliament on an annual basis of the efforts that were undertaken in the area of the implementation of the rights of persons with disabilities.

When Poland joined the Council of Europe in 1991, and, 13 years later, the European Union, it had to participate in European projects, which obliged member states to introduce laws aimed at the welfare of disabled persons. One of the most important legal acts referring to the implementation of anti-discrimination actions related to disabled persons was the European Social Charter. Poland signed the first version of the document dating to 1961 thirty years later (in 1991, having joined the Council of Europe), while the second (amended) version was adopted by all member states in 1996. In the first version of the Charter dating to 1961,part II contained articles devoted to, inter alia, the right to safe and hygienic conditions of work, just remuneration, the protection of children and young people, vocational guidance, health protection, social security, vocational training, and the vocational and social rehabilitation of people with physical or mental disabilities (European Social Charter drawn up in Turin on 18 October 1961, *Dziennik Ustaw* of 1999, No. 8, It. 67, as amended). The second version of the document turned attention, among other things, to the disabled persons' right to equal opportunities and equal treatment in matters concerning employment and the practicing of a profession without discrimination on the grounds of gender and the right to protection against poverty and social marginalisation (European Social Charter (revised) of 3 May 1996).

Another significant document decisive for the situation of persons with a disability was the Council of Europe Plan adopted in 2006 to promote the rights and full participation of disabled persons in society: the improvement of the quality of life of disabled persons in Europe 2006–2015. The main directions of action of the programme were oriented towards the internal politics of the Council of Europe member states and were among other things aimed at ensuring full participation in political, public, and cultural life to persons with disability; the right to education, employment, vocational guidance and training; the right to live in the local community, medical care, rehabilitation, social and legal protection, and protection against violence and abuse.

Poland satisfied the Council of Europe requirements concerning the ensuring of equal opportunities and the delivery of actions aimed at the social integration of disabled persons through the adoption in 1997 of the Charter of Rights of Persons with Disabilities and the drawing up of an act on vocational and social rehabilitation and the employment of disabled persons. It is still (despite many revisions) a legal act which is very significant for the improvement of the quality of life, social and vo-

cational integration and employment of the population in question on the open job market, and introduces a system of subsidies to employers and financial penalties to entrepreneurs, who despite preferential subsidies, do not employ persons with any documented disability (Act of 27 August 1997 on vocational and social rehabilitation and the employment of disabled persons; consolidated text: *Dziennik Ustaw* of 2016, It. 2046, as amended; hereinafter referred to as AVSREDP). The assumptions of the act are discussed in more detail in the chapter concerning the rights of disabled persons in Poland.

Regulations of the European Union were contained in the act of 3 December 2010 on the implementation of some European Union regulations in the area of equal treatment in force as of 1 January 2011 (*Dziennik Ustaw* of 2016, It. 1219). The European Commission has, however, been criticising Poland for negligence in the scope of the implementation of EU regulations. Five procedures were initiated against Poland concerning the non-implementation of the EU anti-discrimination law to the Polish legal system; two of them were taken to the European Court of Justice (Cytowska 2012: 139). For several years now, attempts have been made to implement a draft law prepared by Stowarzyszenie Przyjaciół Integracji, which is aimed at the equalisation of opportunities for disabled persons. It was suggested that it be called an act on the non-discrimination of persons with disabilities or an act on the equalization of opportunities for persons with disabilities. On the International Day of People with Disabilities, 3 December 2008, the document was handed in to the Prime Minister; nevertheless, the further fate of the project remains unknown (Cytowska 2012: 139).

Intellectual disability in the context of the act on the protection of mental health

The main legal act in Poland guaranteeing medical care to persons with intellectual disability and mentally disturbed people is the Act of 19 August 1994 on the protection of mental health (consolidated text: *Dziennik Ustaw* of 2017, It. 882, as amended) (hereinafter: APMH). The act was amended several times, and currently in force is the consolidated text of 5 April 2017 (Notice of the Speaker of the Sejm of the Republic of Poland of 5 April 2017 concerning the announcement of the consolidated text of the act on the protection of mental health, *Dziennik Ustaw*, It. 882). The act on the protection of mental health of 1994 was created on the basis of experience and the related general standards of acts of law concerning mental health in European Union countries and the United States. It was also an answer to the Convention on the Protection of Human Rights and Fundamental Freedoms which Poland ratified in 1993, as resulted from Poland's accession to the Council of Europe. Poland also ratified the International Covenant on Civil and Political Rights in 1977 (Gałecki, Eichstaedt, Bobińska 2012: 525).

Regulations of the act on the protection of mental health of 1994 were divided into 3 groups and are a category of goals that can be described as follows:

- the promotion of mental health and shaping of societal attitudes;
- medical care and assistance in the family and community environments;
- the protection of the rights of mentally disturbed persons.

The first group of provisions of the act aim at the provision of the promotion of mental health and prevention of mental disturbances as well as the shaping of proper societal attitudes to persons with mental conditions: primarily understanding, tolerance, friendliness and prevention of their discrimination. The second group of provisions aim at the provision of multilateral and universally accessible medical care and other forms of assistance indispensable for life in the social and family environments to persons with mental conditions. The third group of provisions aim at the protection of civil rights of persons with mental disorders by strengthening the compliance with the rights specified in the valid acts and guaranteeing the civic rights of patients subjected to compulsory procedures.

The act on the protection of mental health of 1994 concerns three circles of subjects: mentally ill persons (i.e. people with psychotic disorders), mentally disabled persons, and persons suffering from other conditions classified as mental health conditions. It should be noted that all the above individuals are treated in the act as "mentally disturbed persons", and despite the universally recognised and promoted term "intellectual disability", the act, even its latest revision, uses the old nomenclature, i.e. "mental retardation".

In its assumptions, the act on the protection of mental health of 1994 considerably stresses prevention in the area of mental health protection, indicating the necessity to develop various forms of self-assistance: family assistance, community assistance, psychological and social guidance, and the availability of specialist care. Article 8 APMH provides that:

> […] organisational units and other subjects operating on the basis of the act on social assistance […] in agreement with mental health facilities shall organise social support in the area of their operation for persons who due to mental protection or mental impairment experience significant difficulties in their daily life, in particular in shaping their relations with the community in the area of education, employment, and daily life.

The legislature stresses that social support shall in particular involve the development and maintenance of abilities necessary for an independent, active life, the organisation of assistance on the part of family, other persons, groups, and social organisations and institutions in one's community, and the provision of financial aid, in-kind support, and other provisions in compliance with the principles described in the act on social assistance.

Under Article 4 of APMH, preventive actions in the area of the protection of mental health are undertaken mainly in relation to children, youths, the elderly, and

persons experiencing situations posing a threat to their mental health. Such actions include in particular:

1. the application of principles of mental health protection in schools, educational establishments, educational care and resocialization facilities, and military units;
2. the development of entities developing preventive measures, in particular psychological guidance, and specialist facilities, including early diagnosis of the needs of children with disturbed psychomotor development;
3. supporting self-help groups and other social initiatives in the area of mental health protection;
4. the development of preventive measures in the area of mental health protection by medical entities;
5. the introduction of issues related to mental health protection to a programme of the vocational preparation of persons dealing with the upbringing, teaching, resocialization, treatment and care, management and organization of work, and the organization of leisure;
6. research aimed at the improvement of mental health and prevention of mental disturbances;
7. taking into account issues related to mental health in the activity of the public mass media, and especially in radio and television programmes.

The act on the protection of mental health of 1994 also includes the notion of an "informed consent", as defined in Article 3 of APMH. The article provides that informed consent means:

> a consent given freely by a person with mental disorders, who – regardless of their mental health – is truly capable of understanding information provided to them in an accessible way, related to their admission to a psychiatric hospital, their health status, proposed diagnostic and treatment actions and the foreseeable effects of such actions or their negligence.

The above definition applies not only to an informed consent of persons with mental disorders, but also – as explained earlier – persons with intellectual disability. The concept of an informed consent is very significant for every mentally disturbed person in their striving to maintain their individuality and autonomy. In the case of this group of people, this notion is significant and momentous, since in the light of Article 82 of the Civil Code (Act of 23 April 1964 – Civil Code, consolidated text: *Dziennik Ustaw* of 2017, It. 459, as amended; hereinafter referred to as CC) a statement of consent of a mentally disturbed person may be questioned. Questioning one's ability to express an informed consent is based on a wrong presumption that the state of every person suffering from a mental condition excludes free or informed decision-making and expression of will, which leads to an unjustified limitation of the autonomy of such persons. The autonomy of a person suffering from mental disorders, and their resulting right to express a consent or a refusal, may be

limited when the person is unable to provide a significant good for themselves or when they intend to do serious damage to themselves. The Polish legislator in this case uses the principle of paternalism. As a part of paternalism, individuals who are unable to manage their own affairs in a manner objectively good for them need assistance and control from other individuals (groups), who are predestined, or at least have competence, to carry out the function. In psychiatry, indications to use direct coercion appear relatively frequently, and each instance of coercion (direct or indirect)is a violation of an individual's autonomy, which has to be regulated by law. The act on the protection of mental health of 1994 provides that in psychiatry we can differentiate soft and hard paternalism. Soft paternalism applies to persons with deeply disturbed autonomy, for example with psychotic symptoms or severe intellectual disability, which testifies to and indicates their inability to make informed decisions. Hard paternalism allows the protection of individuals against their will, even if they are capable of free and informed choice. Such situations take place when non-psychotic patients are subject to direct coercion or examined or admitted without their consent (Dąbrowski, Pietrzykowski 1997: 27).

In order to protect the rights of patients experiencing compulsory procedures, APMH provides for derogation from the basic rule of consent in the situation of an absolute necessity in Articles 23 (hospitalisation) and 24 (observation). Direct coercion, compulsory examination and admission to a psychiatric hospital for observation or treatment can be used solely when due to the patient's mental disturbances or mental disease, particularly valuable goods such as the patient's life or other persons' life or health are directly jeopardized, and it becomes necessary to subordinate the patient's autonomy to higher order goods (Dąbrowski, Pietrzykowski 1997: 24).

Under Article 29 APMH, admission to psychiatric hospitals applies to persons with mental disturbances, whose behaviour suggests that failure to admit them will significantly worsen their mental condition, or who are unable to independently satisfy their basic needs, with a justified expectation that treatment at a psychiatric hospital will improve their condition; they can be compulsorily directed by a guardianship court to hospital treatment at the request of their spouse, relatives in direct line, siblings, a person authorised to represent them determined by law, or their primary carer. In relation to persons covered by social support, such a request can also be submitted by a municipality or the relevant governmental administration unit. Article 30 APMH provides that the request mentioned above should be accompanied by a report of a psychiatrist justifying in detail the need to treat the patient in a psychiatric hospital. Psychiatrists issue such reports upon reasoned requests of a person or unit authorised to submit a request to initiate the procedure. If the content of such a request or the documents attached to it provide sound reasons in favour of the patient's admission to a psychiatric hospital, and the submission of a report is impossible, the court orders that the person mentioned in the request be subjected to an appropriate examination. The examination can be carried out with-

out the person's consent if he/she refuses to be examined. A decision for the patient to be released from the psychiatric hospital, under Article 35 APMH, is taken by the hospital department head if they recognize that the reasons behind the person's admission to the hospital and stay there, as specified in the act, has ceased to exist. The patient may, after providing a consent at a later date, remain in the psychiatric hospital if, in the doctor's judgement, his/her further stay at the hospital is purposeful. Chapter 4 (Article 38) APMH includes the following provision:

> Who due to their mental disease or mental impairment is unable to satisfy their basic needs and has no possibility to be cared for by other persons and requires constant care and nursing, but does not require hospital treatment, may be admitted to a residential home upon their consent or a consent of their statutory representative.

When a person with mental disorders or their statutory representative fail to agree for their referral to a residential home, while the absence of such care would pose a threat to the person's life, a competent social assistance authority may submit a request for the person to be admitted to a residential home without their consent to the guardianship court competent for the person's residence, as provided in Article 39 APMH. Such requests can also be submitted by the head of the psychiatric hospital if the patient staying at the hospital is unable to independently satisfy their basic needs, and requires permanent care and nursing, while not requiring further treatment at the hospital. Article 39 APMH also provides that if a person in need of a referral to a residential home due to their mental condition is unable to provide their consent to the above, their referral to such a residential home is subject to a decision of the guardianship court. Under Article 42 APMH, when a given person is admitted to a residential home without their consent, their statutory representative, spouse, relatives in the direct line, siblings or primary carer may apply to the guardianship court for a change of its decision on the admission to the residential home. Such a request can also be submitted by the head of the residential home if they decide that the circumstances justifying the admission of the person to the residential home without their consent have changed.

It should be stressed that under Article 43 APMH, judges are authorised to enter psychiatric hospitals and residential homes for persons with mental diseases or mental impairments at any time to control the legality of the admission and stay of persons with mental disturbances in such a hospital or residential home for persons with mental disturbances, to control whether their rights are complied with, and to check the conditions in which they live. Article 48 APMH guarantees that proceedings before the guardianship court in cases determined by the act are free of court costs and that the court may appoint an attorney for the person to whom the proceedings directly apply, even if no request is submitted in this scope, if the person due to their mental condition is unable to submit such a request, and if the court considers the participation of an attorney in the proceedings necessary.

We may point out that the act on the protection of mental health of 1994 on the one hand focuses on the health-related needs of mentally ill persons who pose a threat to themselves and others, and who require treatment – it limits the right to refuse treatment by patients admitted without their consent, determines doctors as persons deciding about the patient's release from the hospital in which they stay under court proceedings, and rejects the idea that a threat to life or health can be the only criterion behind compulsory hospitalisation. On the other hand, it determines relatively precise statutory criteria concerning the application of coercion (direct coercion, compulsory examination, admission, and treatment), provides for a clear system of administrative-medical, court-proceedings and court-control guarantees, and practically limits obligatory treatment to psychiatric hospitals, without extending it to outpatient treatment (Gałecki, Eichstaedt, Bobińska 2012: 530).

Selected aspects concerning the issue of intellectual disability in the context of civil law

The main issues concerning intellectual disability in the area of civil law are: legal capacity and incapacitation, the commitment of tort, responsibility for the damage caused, and defects in the declaration of intent.

Legal capacity and the issue of incapacitation

Article 8 CC provides: "Every human being has legal capacity from the moment of birth", while under Article 11 CC: "Full capacity for legal acts is acquired at the moment of becoming an adult", i.e. upon turning eighteen years of age. However, Article 12 CC stresses that "Individuals who have not attained thirteen years of age and persons fully legally incapacitated do not have capacity for legal acts". Incapacitation is a court procedure aimed at the withdrawal or limitation of the legal capacity of the person it concerns (Łuniewski 1950: 55). It should be noted that incapacitation is a legal measure aimed at the protection of the interest of the person who is to be incapacitated (Uszkiewiczowa 1973: 31–40). Under Article 13 CC:

> § 1. A person who has attained thirteen years of age may be fully legally incapacitated if, due to mental illness, mental retardation or other mental disorder, in particular alcoholism or drug addiction, he is incapable of controlling his behaviour.
> § 2. A guardian is appointed for a fully legally incapacitated person unless the person is still under parental authority.

Summing up, to be incapacitated, a person must be mentally ill, intellectually disabled or present other mental disturbances, which may be related to the abuse of

alcohol or other psychoactive substances and due to such disturbances is unable to control his/her conduct (Pazdan 1997: 59).

Under Article 14 CC: "A legal act performed by a person who does not have capacity for legal acts is invalid", but if such a person "executes a contract of a type commonly executed in minor current day-to-day matters, this contract becomes valid the moment it is performed unless it causes serious harm to the person who does not have capacity for legal acts". Article 16 CC provides:

> An adult may be partially legally incapacitated due to mental illness, mental retardation or other mental disorder, in particular alcoholism or drug addiction, if his condition does not justify him being fully legally incapacitated but he requires assistance to manage his affairs.

Guardianship is established for such persons. Article 15 CC provides that "Minors who have attained thirteen years of age and persons partially legally incapacitated have limited capacity for legal acts". Article 545 of the Code of Civil Procedure (Act of 17 November 1964 – Code of Civil Procedure, consolidated text: *Dziennik Ustaw* of 2016, It. 1822, as amended) enumerates persons authorized to submit a request for incapacitation. They include: a spouse of the person to whom the request for incapacitation applies, their relatives in the direct line, siblings, and their statutory representative. The basis of the court to decide about incapacitation is the manner in which the person to be incapacitated manages her own affairs, whether they pose a threat to their own good or the good of their community, whether their condition or illness affects their understanding of what they do, whether it affects their will, and whether they pose a danger to themselves or their community (Hajdukiewicz 2004: 63). The pronouncement of the full incapacitation in the case of intellectual disability is based on the state of a severe intellectual disability, while in the case of partial incapacitation – states of intellectual disability which are not strong enough to justify full incapacitation (Uszkiewiczowa 1973: 31–40).

Tort and responsibility for the damage caused

Persons with intellectual disabilities may perform tort. The basic rule for the performance of tort is the principle of individual guilt, which results from Article 415 CC. In order to bear responsibility for a deed, there must be damage, a causal act being the root of the guilt and a proximate cause between the deed and the damage (Banaszczyk 1997: 758). Accusation of such a behaviour can be levelled only at a person who acted with full clarity, i.e. when the blame can be laid on them. Article 425 CC provides that: "A person who, for any reason, is in a condition which precludes conscious or free decision-making and expression of will is not liable for damage caused in such a condition". Under Article 82 CC, such conditions include: "mental illness, mental retardation or other, even temporary, mental disorder". The fact of

the incapacitation of the person who caused the damage is of no importance for the making of an allegation. As insightfully pointed out by Zbigniew Banaszczyk, even a person who has been fully incapacitated may act with complete clarity when causing the damage (Banaszczyk 1997: 820). Responsibility for the damage is maintained in the person who consciously and freely makes a decision and expresses their will (Hajdukiewicz 2004: 63).

Persons incapacitated by a valid decision of a civil court may be accused of committing a crime. In its decision of 25 February 2009 (II KK 316/08), the Supreme Court determined that incapacitation as such is not tantamount to insanity of the incapacitated offender. Such a situation only permits evidence from the opinion of expert psychiatrists for the determination of the defendant's insanity, since in the situation in question a doubt arises as to his/her mental state.

Legal acts and defects in the declaration of intent

As far as legal capacity and defects in the declaration of intent are concerned, Articles 82 and 87 CC are very significant. Art. 82 provides that "A declaration of intent made by a person who, for any reason, is in a state which precludes the conscious or free making of a decision and declaring of intent is invalid". Such states include, as aforementioned, severe intellectual disability. It should be noted that what seems to be extremely important in the case of intellectual disability is the aspects of the validity of the declaration of intent such as the awareness of the decision to be made, liberty and the possibility of direct expression (by way of words, writing or implicitly – by gestures or facial expressions) of the person's will. In order to express their declaration of intent in a valid way, persons who are intellectually disabled must understand their decision, and be able to foresee its legal consequences. While choices should be made freely, it should be noted that persons with intellectual disability are easily persuaded, easier give in to pressure from their environment, and seek acceptance while often being unable to rationally foresee consequences of their decisions. Willing to meet the expectations of their environment and be appreciated, persons with intellectual disability may bow to pressure from their environment against their own interest. They may also display a higher tendency to behave in accordance with orders or the context of a given situation. A rational assessment of a decision to be taken largely depends on one's intellectual capacity. The state of intellectual disability, especially if light, does not exclude one's ability to take rational decisions if the matter that the decision concerns as well as the consequences of the decision are presented in a way accessible and understandable to a given person. Summing up, only the state of severe intellectual disability excludes the possibility of an individual making a conscious or free choice and expressing their intent (Gałecki, Eichstaedt, Bobińska 2012: 537).

Selected aspects of intellectual disability in the context of pension certification

As far as forms of the financial security provided to citizens by the state are concerned, there are ill health pensions and disability certification. Intellectual disability is a state of incomplete intellectual development manifesting itself from the earliest developmental years. Persons with intellectual disability who are able to carry out their social obligations in the area of earning income, i.e. persons with mild intellectual disability, may receive pension benefits when, due to co-morbidities, they lose their ability to earn such income. Persons with more severe intellectual disability (moderate or severe intellectual disability) are those unable to undertake vocational activity, and their intellectual disability is noticeable from their earliest developmental years. In the case of children of up to 16 years of age, the so-called disability is certified – which applies in the case of a diagnosed impairment of their physical or mental capacity with the anticipated duration of more than twelve months and the necessity to provide them with full care and assistance from third parties. In such situations, the children's parents may be granted the so-called care allowance. In persons above 16 years of age, certification of the degree of disability applies (Zyss 2009: 218). There are 3 degrees of disability: mild, moderate, and severe. Pension rights are provided to persons with at least a moderate degree of disability. The ill health pension itself is insufficient for rehabilitation, social assistance, and using other rights available to persons with a disability. The act on vocational and social rehabilitation and the employment of the disabled of 1997 specifies 3 degrees of disability: mild, moderate, and severe. Determination of the degree of disability takes place through the certification issued by District Disability Assessment Boards operated by District Family Assistance Centres. Article 4 AVSREDP provides:

> A person with severe disability is a person who has a physical impairment, who is incapable of work or capable of work only under the conditions of protected labour, and who requires permanent or long-term care and support from others in order to fulfil their social roles in connection with his/her inability to live independently. A person with moderate disability is a person who has physical impairment, who is incapable of work or capable of work under the conditions of protected labour, or who requires temporary or partial assistance from others in order to fulfil his/her social roles. A person with mild disability is a person who has a physical impairment causing a significant lowering of his/her ability to work in comparison with the ability of a person with similar vocational qualifications with full mental and physical capability, or who experiences limitations in the fulfilment of their social roles which can be compensated by the supply of orthopaedic, assisting or technical equipment.

In persons with intellectual disability accompanied by other diagnosed disabilities (such as the hearing or vision impairment, motor disability, mental diseases and neurological conditions), the scope of the particular disabilities is determined (Zyss 2009: 219–222).

The current Act of 17 December 1998 on retirement and ill health pensions from Fundusz Ubezpieczeń Społecznych [Social Insurance Fund] (consolidated text: Dziennik Ustaw of 2017, It. 1383, as amended) does not contain any guidelines as to the certification clearly determining how a given condition affects the patient limiting their ability to be employed. The procedure of certification in the area of the attribution of a precise significance for certification to the particular diseases marked by specific severity was shunted to doctors employed with ZUS [Social Insurance Institution] and expert witnesses (Zyss 2009: 232). The Regulation of the Council of Ministers of 15 May 1989 on the rights of employees looking after children requiring permanent care to earlier retirement pension (*Dziennik Ustaw* No. 28, It. 149), which was valid until recently, was the only legal act specifying diseases and attributing specific significance for their certification(Zyss 2009: 232).

Issues described in the above-mentioned regulation of 15 May 1989 include mental disease manifested mainly by an intellectual deficit – including intellectual disability. Ill health pension certification dealt with an intellectual ability of below 90 points of the intelligence quotient. According to the regulation, intellectual disability was divided into six sub-ranges: intelligence below standard (intelligence quotient of 80–89), borderline "retardation" (formerly mental slowness, intelligence quotient of 70–79), and mild/moderate/severe/profound intellectual disability. Complete inability to work was certified on the basis of at least the moderate intellectual disability. More severe degrees of disability, usually related to neurological deficits or epilepsy, were considered sufficient grounds for certifying that the patient was not only completely unable to work, but also unable to live independently. Persons with a mild intellectual disability might require the care from third parties only when their condition was accompanied by other severe comorbidities very seriously hampering the fitness of their body. Mild intellectual disability itself was the basis for the certification of only a partial inability to work. Borderline intellectual disability or intelligence below average were not considered sufficient grounds for certification of even the partial inability to work. In situations when even a mild intellectual deficit co-existed with a deficit in the area of hearing, vision, or mobility or a mental disturbance or disease, it might be considered sufficient grounds for the certification of the complete inability to work. The mental health conditions that very often accompany intellectual disability include conduct disorder and emotional disorders, which, when confirmed with a necessity of treatment, might constitute grounds for the certification of even a complete inability to work (Zyss 2009: 235). Discussing the issue of the financial benefits persons with intellectual disabilities and their families may receive, I should also mention that the guidelines contained in the above-discussed regulation apply to the certification of the scope of a survi-

vor's pension and social pension (Zyss 2009: 240). In the case of intellectual disability, a person is liable for the survivor's pension in the situation of the death of one of the parents regardless of the person's age if the child is completely unable to work or exist independently. The social pension is a financial benefit for persons who fell ill during their childhood or early young age. It should also be noted that severely ill persons requiring assistance from another person are entitled to a benefit in the form of an allowance or care allowance. It is granted to persons who have been certified as completely unable to work and live independently (severe degree of disability). The right to care allowance applies regardless of the amount of income per family member, but it does not apply to persons staying in children's homes, nursing homes, care and treatment facilities or educational care establishments. Care allowance can be granted in the case of very severe conditions such as at least moderate intellectual disability or a milder intellectual disability coexisting with neurological disorders (epilepsy, hearing impairment, deafness, vision impairment, blindness, or cerebrospinal palsy) or mental disturbances considerably hampering daily life. Care allowance is a supplementary benefit paid by social care, while attendance allowance is an insurance-related benefit and is paid by the Social Insurance Institution. A given individual may receive either the care allowance or attendance allowance (Zyss 2009: 216–217).

Selected aspects concerning the issue of intellectual disability in the context of criminal law

Unfortunately, there are no concrete data that might illustrate the phenomenon of crimes committed by persons with intellectual disability in Poland. In this place, I can only quote US research providing that persons with intellectual disability do not commit crimes more often than persons who are intellectually sound (Richard-Devantoy *et al.* 2009 after: Gałecki, Eichstaedt, Bobińska 2012: 530). In another, also US, research (Caldera *et al.* 2009 after: Gałecki, Eichstaedt, Bobińska 2012: 530) a correct thesis was offered that in view of personality traits of disabled persons, including the fact that they are easily suggestible and crave to be accepted by their community, it is highly probable that they will claim responsibility for acts which they did not commit. Persons with intellectual disabilities hardly ever act alone – they are much more prone to carry out somebody else's tasks. The crimes they commit are normally not planned and result from the disturbed control of impulsive behaviours, inability to cope with emotions and stressful situations as well as their inability to foresee consequences. Therefore, they can often result from fear, anger, or panic. Due to their low intellectual abilities, including low ability to plan and foresee, offenders with intellectual disability are more often caught, have a lower chance for self-defence and more often admit their guilt (Caldera *et al.* 2009 after: Gałecki, Eichstaedt, Bobińska 2012: 531).

In the one-but-last subheading, I shall present the most important issues related to the opinions of expert witness psychiatrists in situations when criminal proceedings concern persons with intellectual disability.

Identification of the sanity of the offender from the point of view of the norms of criminal law is very significant, since it is the only circumstance excluding the guilt. Article 1 § 3 of the Criminal Code (Act of 6 June 1997 – Criminal Code, consolidated text: *Dziennik Ustaw* of 2016, It. 1137, as amended; hereinafter referred to as CRC) provides that "The perpetrator of a prohibited act does not commit an offence if guilt cannot be attributed to him at the time of the commission of the act" (Latin *nullum crimen sine culpa* – there is no crime without culpability). What is of key importance for the opinions of expert witness psychiatrists is Article 31 CrC, which reads as follows:

> § 1. Whoever, at the time of the commission of a prohibited act, was incapable of recognising its significance or controlling his conduct because of a mental disease, mental deficiency or other mental disturbance, shall not commit an offence.
> § 2. If at the time of the commission of an offence the ability to recognise the significance of the act or to control one's conduct was diminished to a significant extent, the court may apply an extraordinary mitigation of the penalty.

Article 202 of the Code of Criminal Procedure (Act of 6 June 1997 – Code of Criminal Procedure, consolidated text: *Dziennik Ustaw* of 2017, It. 1904, as amended) (hereinafter referred to as CCP) provides that in order to be able to answer questions concerning the presence of intellectual disability in an offender, expert witnesses psychiatrists are appointed to draw up their opinions on the following basis:

> § 1. At least two expert psychiatrists shall be appointed by the court, and in the preparatory proceedings by the state prosecutor, to deliver an opinion on the mental state of the accused.
> § 2. Upon a motion from the psychiatrists, an expert or experts of other specialties are appointed to participate in preparing an opinion.
> § 3. To participate in the release of an opinion on the state of the mental health of the accused, in terms of sexual preference disorders, the Court, and in preparatory proceedings the Prosecutor, shall appoint an expert sexologist.
> § 4. The experts may not be relatives by marriage or by any other ties which might cast doubt upon their independence.
> § 5. The opinion of the psychiatrists should include statements on both the sanity at the time of committing an act, and also the state of mental health and the capacity to participate in the proceedings […].

The determination of an individual's intellectual level for the purposes of the psychiatric examination in a court case should take place by holding an interview

and checking the individual's intellectual functioning by tests (Przybysz 2003: 27). Under Article 202 § 2 CCP, the task is to be performed by an expert psychologist appointed by the procedural body at the request of expert psychiatrists.

In the context of intellectual disability, the basis for the determination of an individual's insanity upon the commitment of the act is their severe disability or the ascertainment of a mental disease understood as a psychosis or short-term, passing mental disturbances being short-term psychoses, which may coexist with intellectual disability (also of a milder degree). Severely limited sanity can be determined in an intellectual disability, which does not give grounds for the determination of complete insanity, but considerably limits sanity. It should be stressed that both insanity and severely limited sanity are always determined for the time of the commitment of the act and with reference to the concrete prohibited act (Filar 2006: 99). Determination of the individual's insanity involves two compounds: a psychological one and a psychiatric one. Pursuant to the above, the intellectual factor is responsible for the recognition of the significance of an act, while the will factor that is its alternative opposition, is responsible for the possibility for the individual to control their intellect(Filar 2006: 98). Both these elements – psychiatric and psychological – limit each other, since not every mental disturbance gives grounds to determine the individual's insanity – only one leaving the offender unable to recognise the significance of the act or control their conduct, while the absence of these abilities must be caused by the disturbances specified in the psychiatric aspect. In some cases, despite an efficient intellect and undisturbed consciousness, the individual's control of their conduct is disturbed by will-related factors. It would be wrong to say that, in contrast to the above, the offender unable to recognise their acts can control their conduct (Hajdukiewicz 2007: 116).

From the point of view of medicine, the assessment of the offender's sanity is very often ambiguous and may raise doubts and controversies. Sometimes expert psychiatrists appointed by the court or a prosecutor are unable to clearly assess the sanity of the offender in a single outpatient examination. The above also applies to the determination of one's degree of disability, understanding of social rules and manner of functioning. In consequence, the above may be a decisive factor in the determination of insanity or severely limited sanity. Under Article 203 CCP, in the situation when it is absolutely indispensable, psychiatric observation may have to be ruled necessary.

One of the most difficult tasks both for expert witnesses and the court is ruling on liability in the state of insanity or limited sanity resulting from the consumption of alcohol or any other intoxicating agent. Under Article 31 § 3 CrC, insanity or limited sanity do not apply, if: "the perpetrator has brought himself to a state of insobriety or intoxication, causing the exclusion or reduction of accountability which he has or could have foreseen". Marian Filar says in his commentary that insanity or severely limited sanity cannot be adjudged, when the offender has brought himself to the state of insobriety himself, voluntarily, purposefully, and must have foreseen

or at least could foresee the consequences of bringing himself to that state (Filar 2006: 101). Hence, Article 31 § 3 CrC:

> does not apply to persons who were intoxicated against their will or whose intoxication was a result of extraordinary and untypical physiological processes (pathological intoxication or intoxication on pathological grounds). This is because in the above cases the use of alcohol is only a factor intensifying the existing pathological state (such as brain damage, or mental retardation), and not a self-contained reason behind the loss or limitation of sanity (Filar 2006: 101–102).

In cases concerning juveniles, Article 12 of the act of 26 October 1982 on juvenile justice (consolidated text: *Dziennik Ustaw* of 2016, It. 1654, as amended), applies to issues related to intellectual disability:

> If mental retardation, mental disease or other mental disturbance, or habitual consumption of alcohol or other agents with a view to intoxication is determined in a juvenile, the family court may decide to place the juvenile in a psychiatric hospital or any other relevant healthcare establishment. If it appears necessary to provide the juvenile only with pedagogical care, the court may decide to place them in a youth care and education centre, and if the juvenile is severely mentally retarded and requires only care – in a residential home.

Krystyna Gromek identifies the following therapeutic and educational facilities:

a) therapeutic establishments, including psychiatric hospitals and other appropriate therapeutic facilities for juveniles referred to them for additional reasons:
   - independent of their conduct, i.e. mental retardation, mental disease and other mental disturbances;
   - dependent on their conduct, i.e. addictive use of alcohol or other agents with a view to intoxication;
b) care facilities, including residential homes for juveniles requiring only special needs or pedagogical care due to their severe mental retardation;
c) educational care facilities, including educational care facilities for juveniles requiring specialist revalidation and resocialisation impacts (Gromek 2001: 136).

Despite the absence of concrete data presenting the number of persons with intellectual disability or mental disease in prison, the topic does not remain in the sphere of the taboo. Last year, the Polish Office of the Commissioner for Human Rights carried out research during which intellectually disabled and mentally ill persons were identified in prisons, despite the fact that they should never have been placed there. In the course of the Commissioner's conversations with one hundred persons staying in the penal institutions he visited, it turned out that some of them probably should never have been admitted, while others could serve their time under the care of specialists, using therapeutic programmes in the con-

ditions providing security to them, their co-inmates, and the officers, rather than in a standard regime. Such persons are admitted to penal institutions, since information about their disability escapes attention or is not considered significant: policemen do not include it in their reports, prosecutors do not appoint expert witnesses in the case of doubts as to the state of an individual's mental health, courts ignore circumstances showing that a given person may find it problematic to use their rights (no obligatory defendant is provided), and sentences are passed without consideration of the offender's ability to serve a penalty. Sometimes guardians request the imprisonment of someone who failed to pay a fine ordered by the court or perform socially useful work indicated in a court decision, without ever having seen the person, and the court does not check whether the individual can at all serve the given sentence. Members of the Prison Service do not provide significant information about the prisoners to prosecutors, courts, or penal judge, and do not know how to react because they have not been adequately trained. Penal judges do not receive signals that would make them undertake actions as a part of their competences: meeting a given prisoner whose situation requires intervention, issuing guidelines to the Prison Service, or requesting *ex officio* a prison leave (*Więźniowie z niepełnosprawnością intelektualną…* [Prisoners with Intellectual or Physical Disability…] 2016).

According to Prof. Janusz Heitzman from the Institute of Psychiatry and Neurology in Warsaw, law in Poland is good, but poorly applied.

> It should be remembered that one's mental state is affected by social conditions. That is why a single examination can be insufficient, and the evaluation of one's intelligence quotient does not directly translate into what articles can be used. After all, if a person who is intellectually unadjusted to a transformation is admitted to prison, the corrective purpose of the justice shall not be achieved (*Więźniowie z niepełnosprawnością intelektualną…* [Prisoners with Intellectual or Physical Disability…] 2016).

After Adam Bodnar's interviews with the sentenced individuals, the Office of the Commissioner of Human Rights is currently analysing their documents in terms of their possible cassation or applying to the court for revision. Perhaps some of these cases will qualify for the President to consider the granting of clemency to some of the sentenced individuals.

Controversy as a part of family and guardianship law – the right of persons with intellectual disability or mental disease to enter into marriage

The controversy in the Polish law as specified in the title is constituted by Article 12 of the family and guardianship code (Act of 25 February 1964 – Family and

Guardianship Code, consolidated text: *Dziennik Ustaw* of 2017, It. 682, as amended), under which: "Persons suffering from mental diseases or mental retardation cannot enter into marriage. If, however, their state of health or mental condition do not pose a risk to marriage or the health of the future offspring and if they have not been fully incapacitated, the court may allow them to enter into marriage".

In November 2016 a case brought by the Commissioner for Human Rights was finalized in the Constitutional Tribunal. It was inspired by a concrete event: a registrar refused a woman with cerebral palsy to marry, since she had problems with speaking (being fully sound intellectually). During the hearing before the Tribunal, a representative of the Commissioner for Human Rights argued that the regulation is discriminative, causes the sense of debasement and humiliation, violates one's dignity and the right to family life. According to her, the Article is based on a eugenic motivation: making the procreation of intellectually disabled people more difficult. However, from the scientific point of view, a mental disease or disability do not have to be inherited. Modern medicines allow to control the mental disease in such a way that ill individuals often function normally in their family and social community. The representative of the Commissioner for Human Rights also stressed that marriage is going to have a beneficial effect on the ill individual: "The regulation originates from the times when people believed that mentally ill individuals should be isolated from society. Today we know that they should be particularly included. Also, an absence of marriage does not make procreation impossible. As results from an examination of the records, the majority of persons who tried to win a court's consent to marriage either already had children or were expecting them" (Siedlecka 2016). It clearly results from the above report that the relative ban on marriage for such persons is a non-proportional and unnecessary measure.

The right to enter into marriage by persons with intellectual disability on equal terms with other individuals is included in the UN Convention on the rights of persons with disabilities drawn up in New York on 13 December 2006 (*Dziennik Ustaw* of 2012, It. 1169). Poland ratified the convention in 2012, but made a reservation in relation to the point concerning the equality of persons with intellectual disabilities in marriage and other civil rights. For this reason the Commissioner for Human Rights could not refer to the Convention in his complaint to the Tribunal. In the times of the rule of Platforma Obywatelska [Civic Platform]works were in progress in the Ministry of Justice on adjusting the Polish regulations in this scope to the convention, but they were not finished. Currently, in connection with the liquidation of the Civil Law Codification Commission operating under the auspices of the Minister of Justice, the issue is not progressing at all.

The Constitutional Tribunal did not consider the arguments of the Commissioner for Human Rights as right. The judge and legal expert Andrzej Wróbel underlined that the Polish Constitution does not contain the right to marry, and the right to family life included in Art. 47should be read in the context of Article 18, which provides for the protection of marriage, family, and parenthood: "The Con-

vention on the rights of persons with disabilities considers individual freedom as the highest value in the context of marriage, while Polish law – the protection of marriage, family, parenthood, and the interest of the child" (Siedlecka 2016). He also stressed that the limitation of the right of persons with intellectual disability to enter into marriage is to protect the values. The Tribunal also disagreed with a view that the regulation violates the principle of respecting human dignity. According to the Tribunal, in this case one could talk about the violation of dignity understood not as every individual's constitutive trait, but as a violation of personal dignity, which can be limited, similarly to other human rights and liberties, e.g. in view of the protection of other persons' rights and liberties. And, according to the Tribunal, this is so in this particular case – in particular this is about guaranteeing the safety and interest of children (Siedlecka 2016).

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Summary

The rights of persons with intellectual disability in the light of European and Polish legislation

Preliminary results of the 2011 National Population Census concerning the disabled population show that the number of people qualifying for classification to this community

amounts to 4,697,500, which constitutes 12.2% of the Polish population. This article seeks to analyse and discuss the main assumptions contained in selected provisions of Polish and European legislation with particular focus on the issues directly related to the disabled and people with mental disorders.

Keywords

disability, mental disorders, incapacitation, Polish law, European law

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Tłumaczenie sfinansowano ze środków Ministerstwa Nauki i Szkolnictwa Wyższego na podstawie umowy nr **661/P-DUN/2018** z dnia 13 lipca 2018 roku w ramach realizacji zadania 1 – stworzenie anglojęzycznych wersji wydawanych publikacji w 2019 roku.
The translation was financed with funds made available by the Ministry of Finance and Higher Education under contract No. **661/P-DUN/2018** of 13 July 2018 as a part of the execution of task 1: the creation of English-language versions of the issued publications in 2019.